WORKING TOGETHER TO ACHIEVE BETTER HEALTH FOR ALL

Southwestern Ontario
Comprehensive Health System Planning Commission

FINAL REPORT

DECEMBER 1991

WORKING TOGETHER TO ACHIEVE BETTER HEALTH FOR ALL

FINAL REPORT

SOUTHWESTERN ONTARIO
COMPREHENSIVE HEALTH SYSTEM PLANNING COMMISSION

December 1991

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December 20, 1991

The Honourable Frances Lankin
Minister of Health
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto, Ontario
M7A 2C4

Dear Minister:

We are pleased to submit the Final Report of the Comprehensive Health System Planning Commission of Southwestern Ontario.

In the Spring of 1990, the Comprehensive Health System Planning Commission was formed by the Honourable Elinor Caplan, then Minister of Health. Your Government has expressed its support for the Commission and its mandate.

In responding to our mandate, we have accepted the values and principles, together with the strategic framework, objectives, and targets of the Premier's Council on Health Strategy. Through operationalizing the Premier's Council framework, we have prepared a 10-year plan for meeting the special health care needs of the Southwest Region. We have developed a structure of governance and administration required to implement the plan and provide for the ongoing management of health care in the Region. Finally, we have quantified the plan so far as possible, so that its dimensions may be understood and, subsequently, evaluation of its achievement can be made.

Conclusions implicit in the Commission's plan are:

- The collection of counties and municipalities that comprise Southwestern Ontario constitute a logical region for planning and management.

- The Region is "self-sufficient" in the sense that the health needs of residents can be met in the Region.

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- The special needs of the people in Southwestern Ontario can be identified and responded to.
- The Health Sciences Complex will continue to maintain its national and international reputation in academic medicine, research and care.
- Regional and Area systems of governance and administration can allocate resources more productively, efficiently, and more responsively to community needs, than existing structures.
- Systematic planning and effective management can contain the annual increase in health care expenditures to three percent without inflation.
- A shift in emphasis to health promotion and disease prevention can be achieved.
- The Region can evolve to a higher proportion of home-based care.
- Progress can be made in providing care "closer to home".

In August, 1991, the Commission issued a Preliminary Report on its plan to the people of Southwestern Ontario. Community "round table" meetings were held in each county within the Region during September and October 1991. More than 800 representatives from community groups, service providers, consumers, and other organizations with an interest in health, took this opportunity to discuss and debate the plan. Their views and comments were taken into consideration in the preparation of our Final Report.

At a time when the effectiveness and costs of our health system are being questioned as never before, this plan challenges everyone interested in the health system in Southwestern Ontario to assume responsibility and accountability for providing health care services and to improve health within our financial means. We believe that the people of the Region are able and prepared to make the decisions necessary to achieve the objectives outlined in our plan. With respect to its implementation, it should be possible to have the new Regional and Area Health Management Boards in place to commence operation at the beginning of the 1994/95 fiscal year.

We would like to thank you for the opportunity to participate in this challenging and rewarding process. We firmly believe that this plan will help the Provincial Government and citizens of Southwestern Ontario deal with the significant issues we all face in meeting our health needs.

Yours sincerely,

Earl Orser

Earl Orser, Chair

Catherine Dunlop

Catherine Dunlop

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D Lawson

Douglas Lawson

Verna Mai

Verna Mai

Kathy Desai

Kathy Desai

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* Dr. Gunton's endorsement does not include certain matters relating to the Health Sciences Complex. See note in Appendices under Conflicts of Interest.

ACKNOWLEDGEMENTS

The Comprehensive Health System Planning Commission
would like to thank the following for their contributions:

Secretariat and Support Staff

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The Commission would also like to express its appreciation to the many other individuals and groups who volunteered their time, experience and support throughout its work.

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EXECUTIVE SUMMARY

WORKING TOGETHER TO ACHIEVE BETTER HEALTH FOR ALL

Background

Health is viewed by people and their governments to be a valuable resource which should be maintained at its highest possible level. Today, more than $2.1 billion is being spent each year on the delivery of health care in Southwestern Ontario. By the year 2001, health care costs for the Region will likely be in the order of $3.7 billion.

In February 1990, the Comprehensive Health System Planning Commission was established by the then Minister of Health with the mandate to develop a ten-year strategic plan for the total health care system in Southwestern Ontario. This plan was to be designed to provide accessible, affordable, effective, and appropriate health services for all people throughout the Region.

Commission Process

In undertaking this task, the Commission adopted a phased process which included:

- **Preliminary Assessment** of the health care system and the health issues in Southwestern Ontario through meetings with government officials and industry representatives and research into the work of previous commissions;
- **Initial Public Consultations** to learn, first-hand, about health issues and concerns. A series of open meetings were held throughout the Region with representatives of the public, service providers, and special interest groups;
- **Research and Analysis** of the key issues by means of consultations with industry experts, in-depth studies by Task Force groups and special surveys of health facilities;
- **Development of the Plan.** Using information obtained from the preliminary assessment, public consultations and research and analysis, the Commission prepared a plan and published a Preliminary Report which responded to its mandate.

- **Public Consultations** ("Round Table Meetings") to obtain feedback on the Preliminary Report, and
- **Reporting** back to the Minister of Health. The Final Report was prepared, taking into consideration the views and opinions expressed during a second series of public consultations.

A number of members of the Commission are engaged in professional and management activities providing health care as practitioners or in hospitals or other organizations. It was the Commission's procedure that these Commission members participated in all discussions but refrained from voting on matters in which they deemed themselves to be in conflict. Such situations are recorded in the Commission's meeting minutes. The Commissioners affected are listed in the Appendix titled "Conflicts of Interest".

Our Health System Today : The Need for New Directions

The people of Southwestern Ontario enjoy the benefits of one of the best health systems in the world. However, members of the public and service providers have many concerns over the availability, quality and appropriateness of health services throughout the Region. The health system must become more responsive to Regional health needs and concerns and people within the Region must become more involved in making decisions which affect their health and well-being. Over the longer term, the broad determinants of health, including social, economic, environmental, and lifestyle factors, must be addressed through a more comprehensive approach to improving health.

Underlying these changes will be the need to increase the overall efficiency and effectiveness of the health system, since the growth in health care spending across Ontario will be contained by the Provincial Government. The collaborative efforts of all people involved in providing and receiving health care will be required in order to ensure that every health care dollar is spent in the best possible way to obtain the best possible health outcome for the people of Southwestern Ontario.

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The Plan : Towards Better Management of Our Health

The major focus of the health system in Southwestern Ontario will be broadened in scope from the treatment of illness and injury in institutional settings to include greater emphasis on the promotion of improved health and the provision of services in community settings or in the home, where this is feasible and beneficial to recipients and their families.

Building on the framework recommended by the Premier's Council on Health Strategy, the Commission's plan is designed to establish a health care system governed and managed at the Regional level.

The plan reflects five key underlying strategies:

- establishment of a regional structure of governance for the total health care system in Southwestern Ontario;
- investment of increased resources in health promotion and disease prevention;
- provision of more health care closer to home through the enhancement of services in the community and the enhanced capability of community hospitals;
- establishment of an integrated approach to planning, managing, and educating the human resources which are required to meet the health care needs of the Region, and
- a capital investment strategy which is designed to increase the overall efficiency and effectiveness of the health care system and provide new, more cost-effective services while achieving the necessary improvements to obsolete or inadequate health facilities.

A Regional Governance Structure

At present, there are no well-understood Provincial strategies for improving health, nor any comprehensive planning guidelines for regions, communities and service providers to identify and meet their health needs. It is virtually impossible to plan and manage effectively the health care system in Ontario on a centralized basis; the Province is too large, too populous, and the diversity of character and needs of its many regions, areas and communities is too great. It will, therefore, be necessary to divide the Province into several regions, such as Southwestern Ontario, which, by virtue of their population size, health needs, and patterns of health care activity, can be managed on a self-sufficient basis.

Fundamental to the achievement of improved health in Southwestern Ontario, will be the devolution of management, planning and decision-making responsibility from the Provincial Government to the Regional level, where the health system can be planned and decisions made most effectively, taking into consideration the specific needs and relative priorities expressed by the people of the Region.

A Southwestern Ontario Health Management Board will be established and held accountable jointly to the Provincial Government and to the people within the Region for overall management of the health care system in the Region. This Board will be responsible for long-term planning of the overall system, allocating operating funds, approving capital expenditures, managing human resources and providing support for the coordinated education of health professionals throughout the Region. A Regional Health Sciences Management Board will be responsible to the Southwestern Ontario Health Management Board for overseeing the system for providing tertiary care services throughout the entire Region. Area Health Management Boards will be responsible for the system of health services within six specific geographic areas which comprise Southwestern Ontario. These Boards will not be direct providers of health care services, nor will they manage individual service providers or other elements in the health care system.

The Southwestern Region will be allocated a funding envelope from the Provincial Government for the total management and operation of its health system. This envelope will include operating and capital funds for institutions and community agencies and funding for

OHIP payments, drug benefits, public health programs, and other health services in the Region. The Southwestern Ontario Health Management Board will be responsible for allocating funds to the Regional Health Sciences Management Board and the six Area Boards. In turn, these Boards will be responsible for allocating funds to the service providers within their respective areas. Over time, funding in the Region will shift from the existing incremental approach to a system based on a more integrated and cost-effective approach to meeting the health care needs in each local community.

The new Regional and Area Health Management Boards will be governed by appointed boards of directors which include representatives from the public, local government and service providers within the Region. These boards will be responsible for enhancing the roles of service providers, including the important role of the Health Sciences Complex in academic medicine, research and tertiary care at a regional, provincial, and national level. They will also ensure that representatives of the public play an important role in identifying health needs and planning new programs and services at the community level, through the support of local advisory groups which focus on specific health issues.

Boards of governors of hospitals and other service providers will continue to discharge their existing responsibilities, while working in closer collaboration with one another and with the Area and Regional Boards to improve the efficiency and effectiveness of the health system. The Ministry of Health will maintain its existing role in establishing and enforcing overall policies, standards and guidelines for the provision of consistent health care across the Province.

Improved Health Promotion and Disease Prevention

The development of health promotion and disease prevention programs in Southwestern Ontario will be based on the following principles:

- direct involvement of people in making decisions concerning their health;

WORKING TOGETHER TO ACHIEVE BETTER HEALTH FOR ALL

- development of stronger family and community supports which enable individuals to maximize their potential for good health within their own homes and communities;
- improvements addressing the social, economic, environmental, and lifestyle factors which influence health and illness, and
- the use of a wide range of approaches, such as education, research, legislation and community development policies.

Over the next ten years, an additional one percent of total health care system spending will be allocated to health promotion and disease prevention from within the funding envelope provided to Southwestern Ontario. Health promotion and disease prevention efforts will cover a wide range of needs and issues, but the primary focus will be on six high priority areas including:

- development of healthy children;
- reduction of coronary heart disease;
- promotion of healthier workplaces;
- prevention of substance abuse;
- development of increased health promotion knowledge and skills, and
- coordination of health and environmental planning.

Service Enhancements

The share of total health system funding devoted to community services will be doubled over the next ten years. A spectrum of viable services will be established in each community based on need and economic justification. Initiatives will be undertaken to facilitate training and attract the necessary health professionals to provide these services. At the same time, concerted efforts will be made to reduce the existing fragmentation of service providers and improve the overall cost effectiveness of community services.

Coincident with the development of community services, acute care hospital services will be rationalized throughout the Region through the reduced use of hospital beds and the increased capability of community hospitals to provide secondary acute care services.

The Health Sciences Complex will be encouraged to rationalize its services and to enhance its role in providing leadership and coordination of health education and research efforts throughout all parts of Southwestern Ontario.

In conjunction with the Provincial Government's initiative to redirect the provision of long-term care services in Ontario, support systems for delivery of services in people's homes and in the community will be increased and the inappropriate use of institutional settings for long-term care will be reduced.

Management of Human Resources

The development and implementation of a human resources plan for Southwestern Ontario will focus on the identification of specific underserviced and overserviced areas with respect to professional, managerial, technical and non-professional resources. Human resources needs will be met through an overall approach to planning which involves the substitution of health professionals, reorganization of services, and financial incentives. There will be some decentralization of the education of health professionals in order to provide practical experience in local settings.

In the future, institutions involved in the education of health professionals throughout Southwestern Ontario will be encouraged to include in their education programs, such principles as the broad determinants of health, the development of community services, multi-disciplinary approaches to care delivery, health care economics, and the importance of health promotion and disease prevention.

A human resources plan for managing physician services will be established. This plan will include measures to manage the number, location and types of physicians necessary to meet the health needs of the Region, consideration of alternate funding arrangements to reduce the growth in the total cost of physician services and the establishment of a Utilization Review Board to monitor service utilization.

Capital Investment

The development of health facilities in Southwestern Ontario will be based on an integrated, ten-year capital spending plan. All capital projects will be required to reduce the overall operating costs of the health system by an amount which is at least sufficient to offset the cost of capital. This plan will include the following five strategies:

- implementation of hospital bed targets for acute and chronic care to the year 2001;
- optimum utilization of health facilities;
- rationalization of health services among institutional and community-based service providers, particularly in areas served by two or more hospitals;
- reduction of operating costs through increased productivity, and
- the provision of minimum acceptable standards of accommodation for patient care and access for disabled persons.

Over the next ten years a total of $550 million will be invested in developing and upgrading health facilities throughout the Region. This investment will be made according to the following framework:

- $100 million for the enhancement of viable community hospitals;
- $150 million for the rationalization and consolidation of services;
- $110 million for the consolidation of Victoria Hospital in London on the Westminster Campus;

- $65 million for the facility needs of St. Joseph's and University Hospitals in London;
- $50 million for upgrading engineering and building systems in existing facilities, and
- $75 million for the enhancement of long-term care facilities including the replacement of the Riverview Unit at the Windsor Western Hospital Centre and St. Mary's Hospital in London.

Reallocation of Resources

It is understood that the share of Provincial Government expenditures represented by health care will not increase in the future.

As a result, without inflation, Provincial funding for health care in Ontario is expected to increase at an average rate of only 3.0 percent per year to the year 2000/01 (the estimated annual rate of growth of the Gross Provincial Product) compared with an actual increase of 5.5 percent between 1980/81 and 1990/91.

Given this reality, implementation of the plan will be accomplished through the reallocation of existing health system financial resources from one category of spending to another and through improvements in effectiveness and efficiency.

Implementation

Successful implementation of the plan will require significant changes in how people view health and how they work together to maintain good health and to plan, manage and provide appropriate health services.

An implementation body will be established on an interim basis in order to ensure an effective and efficient transition to the new regional system of governance.

Among the important issues to be considered in the implementation process will be the establishment of the necessary legislative and policy framework at the Provincial level to create the new Regional and Area Boards and to enable them to fulfill their mandate successfully. A careful, planned approach to the transfer of responsibilities and resources from the Provincial Ministries and the District Health Councils in Southwestern Ontario to the new boards will be required in order to avoid the duplication of resources and structures.

Highly committed and objective board members and highly qualified executives with demonstrated management skills will be essential for the effective governance and management of the Regional and Area Health Boards. Effective communication of the plan to all citizens of the Region and the participation of all key players will be critical to developing and implementing future changes to the system. Successful implementation of the plan will also depend upon community-minded and highly motivated volunteers continuing to play an important and essential role in the delivery of health care through the donation of time, services and fresh ideas for improving the health system.

Conclusion

Today, many concerns exist with respect to the health of the people of Southwestern Ontario and the ability of the health system to meet future needs within the limitations which must necessarily be imposed on the funding of health care. Despite these problems, the strong base of services and the large and diverse group of highly skilled and motivated people within the health system provide the basis for much optimism for the future. The establishment of a regional health system will provide the opportunity for people within the Region to make their own decisions with respect to health care and to create more collaborative and innovative ways for achieving improved health for all.

OUR HEALTH NEEDS AND PRIORITIES: IMPROVING HEALTH FOR ALL

OUR HEALTH NEEDS AND PRIORITIES: IMPROVING HEALTH FOR ALL

Summary

A CHANGING CONCEPT OF HEALTH

For most of this century, the concept of health and its improvement has been linked closely with the treatment of illness and injury through curative medicine. Advances in medical research and medical care have improved life expectancy and quality of life for many individuals who have experienced illness and injury. Medical care will continue to play an important role in maintaining and improving the health of the people of Southwestern Ontario.

Since the early 1970s, a broader view of health and its determinants has emerged in Canada and many countries around the world. Health is viewed as a resource which should be maintained at its highest possible level. In addition to the quality of available medical care, social and physical environments, economic status and individual lifestyle are all important contributing factors to the quality of health.

Today, the majority of Canadians feel healthy and most make some effort to improve their health. However, underlying concerns exist with respect to the health status of Canadians. For example, people with lower incomes, fewer community and family supports and higher levels of stress are not as healthy, nor do they feel as healthy as those who are better off financially and have stronger support systems.

What is Health?

A CHANGING CONCEPT OF HEALTH

Introduction

Health is a state of well-being to which everyone strives. Good health leads to a feeling of power and control over oneself and one's environment. It helps in dealing with stress and the set-backs which people face during the course of their lives. Good health enables people to achieve the aspirations and goals which they hold for themselves and their families.

Health is a resource which is often taken for granted. It is something that is often valued most highly when it no longer exists. At those times, health is widely recognized as a basic necessity for living a productive and satisfying life. Health is not simply the absence of disease. Good health can be enjoyed by people with disabilities or chronic disease.

Historical View of Health

For most of this century, the concept of health has been linked most closely with the treatment of illness and injury through curative medicine. The improvement of health has taken place largely within hospitals and doctors' offices where medical interventions have been provided to those people with the most serious health problems.

During this century, major advances in medical technology, research, and in diagnostic, treatment and rehabilitation techniques have improved the overall life expectancy of the population and the quality of life for many people who have experienced illness and injury. For example, improvements in the diagnosis and treatment of diabetes, cancer and heart disease have reduced significantly mortality rates and disabilities previously associated with these diseases.

Advancements in medical techniques and technology will continue to play a critical role in improving the health and well-being of the population of the Southwest Region.

A CHANGING CONCEPT OF HEALTH

OUR HEALTH NEEDS AND PRIORITIES: IMPROVING HEALTH FOR ALL

What is Health?

"Marvelous though health care services are in Canada in comparison with many other countries, there is little doubt that future improvements in the level of health of Canadians lie mainly in improving the environment, moderating self-imposed risks and adding to or knowledge of human biology."

Source: Department of National Health & Welfare (Canada)

The Emerging View of Health

In 1974, the Federal government of Canada published "A New Perspective on the Health of Canadians", which identified the important role that social and physical environments, lifestyle and behaviour play in determining individual health. Since that time, further research has identified other important factors which affect health, such as economic well-being, early childhood experience and the workplace environment.

As a result of national and international studies (including the Premier's Council on Health Strategy report on Nurturing Health in 1991), the concept of health is expanding from the traditional focus on curative medicine to a broader perspective which includes the many determinants of individual health. For example, the World Health Organization defines health as follows:

> *"Health is the extent to which an individual or group is able, on the one hand, to realize aspirations and satisfy needs; and on the other hand to change or cope with the environment. Health is therefore seen as a resource for everyday life, not an objective of living; it is a positive conception emphasizing social and personal resources, as well as physical capacity."*

The fundamental change in the concept of health has presented a major challenge to the health care system in two respects. First, in addition to continuing to treat illness and injury, increased emphasis has been placed on health promotion and disease prevention in an effort to address the underlying factors which contribute to the development of health problems. The second impact has been the need to focus on issues such as the environment and the economic status of individuals which, while very important determinants of health, are beyond the immediate control of the health care system.

At the same time individuals have begun to assume more responsibility for their own health through improved lifestyles involving proper diet, exercise, the elimination of smoking and the reduced consumption of alcohol.

Broad Determinants of Health

Access to the health care system is important to maintaining health through treatment of, and rehabilitation from, disease or accidental injury. However, the development and maintenance of good health requires more than just a good health system. Healthy individual lifestyles, safe and supportive families and communities, meaningful employment opportunities, social justice and economic prosperity are all factors which have been linked in previous studies to health. Appropriate housing, transportation, income support, and environmental protection also have a significant influence upon health.

One of the most significant of these factors is the social environment, and, in particular, socio-economic status. Experience has shown that people who live alone or who have lower incomes have more health-related problems than those who live with others or have above-average incomes. Differences in health status appear to result from such factors as early childhood experience, family and friendship supports, workplace hazards, position in the work hierarchy and exposure to a toxic physical environment. People with low incomes often have limited support and capacity to cope with their own life stress and that of family members.

Health is also determined, in part, by inherited susceptibility to disease and how individuals respond to disease or disability. For people who have a strong constitution and a positive outlook, disease may have a minimal impact. For others, stress and limited social support may increase the risk of developing disease.

Components of a Healthy Community

In recognition of the broad determinants of health and the significant role which communities can play in maintaining and enhancing the health of their citizens, the Canadian Healthy Communities Project has adopted the World Health Organization definition of the qualities which a healthy community should strive to provide:

- a clean, safe physical environment (including quality housing);
- an ecosystem that is stable and sustainable;
- a strong, mutually supportive community;
- a high degree of participation and control by the public over decisions affecting their lives, health and well-being;
- basic needs including food, water, shelter, income safety and work for all the community's people;
- access to a wide variety of experiences, resources, and interaction with others;
- a diverse, vital and innovative economy;
- connectedness with the cultural and biological past and present;
- an optimum level of appropriate public health and sick care services accessible to all, and
- high levels of positive health and low levels of disease.

Health Status of Canadians

There is little factual information available with respect to the health status of the population in Canada. However, based on a 1985 Federal Government study of people's views concerning their health, the majority of Canadians feel healthy. According to "The Active Health Report: Health Promotion Survey 1985", the report on Canada's first health promotion survey undertaken by the Federal Department of Health and Welfare, some 61 percent of Canadians rated their health as very good to excellent. Even those that had a disease limiting their activity felt healthy. Some 30 percent of those with limitations in activity believed that their health was very good or excellent and another 30 percent that their health was good. Many Canadians also felt that they worked hard to improve their health. Almost two-thirds of the respondents felt that they made more of an effort to maintain good health than others their age.

According to the same survey, peoples' sense of well-being is related to level of income. Three-quarters of people in the highest income bracket rated their health as very good to excellent compared to only one-half of those in the lowest income bracket.

OUR HEALTH NEEDS AND PRIORITIES: IMPROVING HEALTH FOR ALL

Summary

Today, there are more than 1.3 million people living in Southwestern Ontario, more than the population of six of the ten provinces in Canada. Approximately one-half of the population in the Region lives in the counties of Middlesex and Essex which include the Region's two largest cities of London and Windsor respectively. There are wide variations in population densities and in the distribution of people between urban and rural settings in the ten counties which make up the Southwest Region.

Over the next ten years, the population in Southwestern Ontario is expected to grow by 98,000 people (7.2 percent). The proportion of the population which is 65 years and older, is expected to grow by 1 percent over this same period. The overall growth rate and aging of the population will be less in Southwestern Ontario than in the Province as a whole.

The patterns in the level of education in Southwestern Ontario are similar to those in Canada and in most other regions within Ontario. More than twice as many people are employed in primary industry (principally in farming) in Southwestern Ontario than in the Province as a whole. The average income per capita in the Region is 9 percent lower than the Ontario average. In addition, the proportion of people living in low income households is almost 18 percent higher than in the entire Province. Average unemployment rates in the Region currently exceed those in the entire Province.

OUR HEALTH NEEDS AND PRIORITIES: IMPROVING HEALTH FOR ALL

Demographic Profile

THE PEOPLE OF SOUTHWESTERN ONTARIO

Where People Live in Southwestern Ontario

Today, there is an estimated total of more than 1.3 million people living in Southwestern Ontario. This figure represents 13.7 percent of the total estimated Ontario population of 9.9 million. There are more people living in this Region than in six of the ten provinces in Canada.

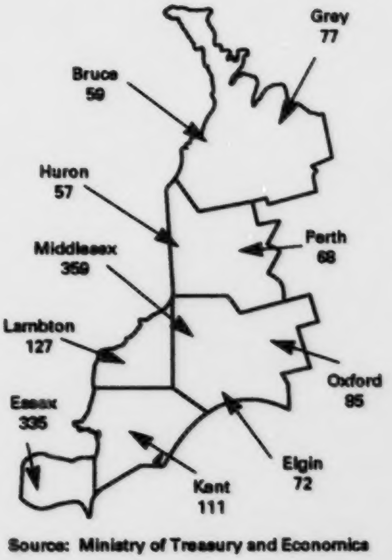
Number of People Living in Southwestern Ontario in 1991

Ontario
Southwestern Ontario
1.3 Million

Source: Ministry of Treasury & Economics

Ten counties make up the Region of Southwestern Ontario. People are distributed unevenly throughout these counties. The Counties of Middlesex and Essex, which include the Region's two largest cities of London and Windsor respectively, together comprise approximately one-half of the entire population of Southwestern Ontario.

Population of Southwestern Ontario By County in 1991 (000s)

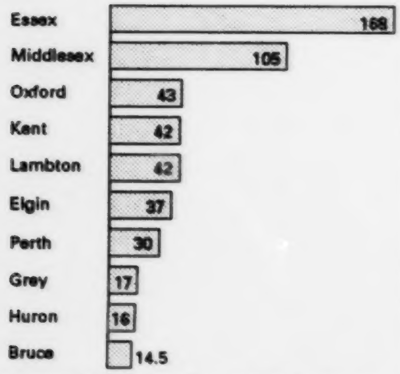

Grey
77
Bruce
59
Huron
57
Perth
68
Middlesex
359
Lambton
127
Oxford
85
Essex
335
Elgin
72
Kent
111

Source: Ministry of Treasury and Economics

OUR HEALTH NEEDS AND PRIORITIES: IMPROVING HEALTH FOR ALL

Demographic Profile

Number of People per Square Kilometer by County in 1991



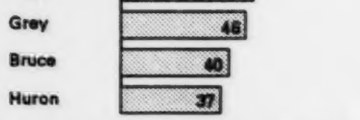
Source: Ministry of Treasury and Economics

Population Density

Essex and Middlesex Counties are also the most densely populated areas of the Region. In contrast, the four northernmost counties of Perth, Grey, Huron and Bruce are sparsely populated with densities of between 10 percent and 20 percent of that of Essex County.

It is more difficult to provide access to health care services for people in the sparsely populated counties compared to the more densely populated areas.

Percentage of Urbanized Population by County in 1988



Source: Ontario Ministry of Municipal Affairs

Urban and Rural Population

There is also a marked difference in the distribution of people within the ten counties of Southwestern Ontario. In seven out of the ten counties, most people live in urban settings. The majority of people in the Counties of Middlesex, Essex, Kent, Lambton, Perth, and Oxford live in urban centres while the people in Elgin, Grey, Bruce, and Huron Counties live mostly in rural settings.

OUR HEALTH NEEDS AND PRIORITIES: IMPROVING HEALTH FOR ALL

Demographic Profile

THE PEOPLE OF SOUTHWESTERN ONTARIO

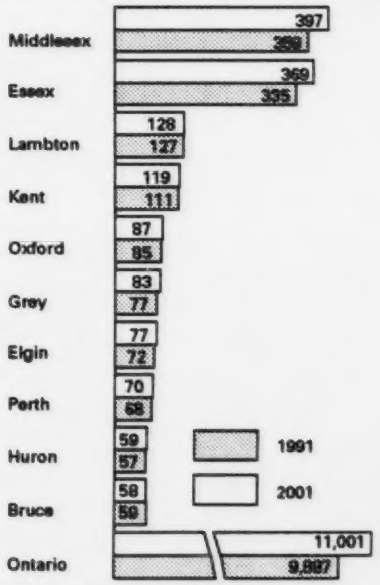
How the Population is Changing

Projected Population Growth

Between 1991 and 2001, the population of Southwestern Ontario is expected to grow by some 98,000 people or by 7.2 percent. Almost three-quarters of this growth will occur in the two most populated counties of Middlesex and Essex. The population of Kent County is expected to increase by the same rate as the entire Region, while the counties of Lambton, Oxford, Elgin, Perth, and Huron will experience slower growth rates and Bruce County will experience a slight decline in total population.

Over the next ten years, the rate of population growth in Southwestern Ontario will be significantly less than the overall growth rate in Ontario of 11.3 percent.

Estimated Population by County (000s)



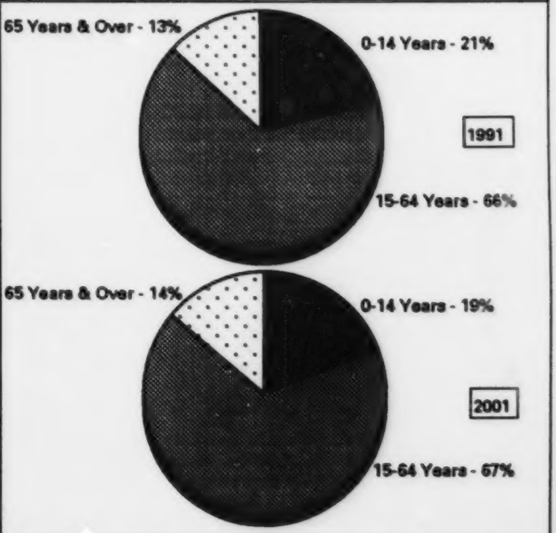
Source: Ministry of Treasury & Economics

Aging

Like elsewhere in Canada and many other industrialized countries, Southwestern Ontario has an aging population. Between 1991 and 2001, the percentage of people under the age of 15 is expected to decline by 2 percent while the proportion of those 65 years and over to increase by one percent. This will mean a total increase in the number of elderly residents of approximately 24,500 over the next ten years.

The rate of growth in the elderly population in Southwestern Ontario will be 1.3 percent per year, less than one-half of the expected Province-wide growth rate of 2.7 percent per year. By the year 2001, Southwestern Ontario is expected to have 14 percent of its population over 65 years compared to a Province-wide figure of 13.4 percent.

Distribution of People by Age Group

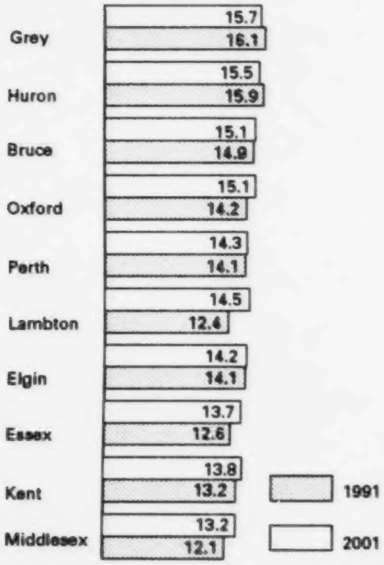


Source: Ministry of Treasury & Economics

OUR HEALTH NEEDS AND PRIORITIES: IMPROVING HEALTH FOR ALL

Demographic Profile

Estimated Growth in the Percentage of the Population 65 Years of Age and Over by County



Source: Ministry of Treasury and Economics

The aging of the population will be unevenly distributed throughout Southwestern Ontario. Grey and Huron Counties, which already have the highest percentage of population 65 years and over, will experience a slight decline in the proportion of elderly people. The greatest increase in the percentage of population 65 years and over will occur in Lambton County, followed by the two most populated counties of Essex and Middlesex and the Counties of Oxford and Elgin.

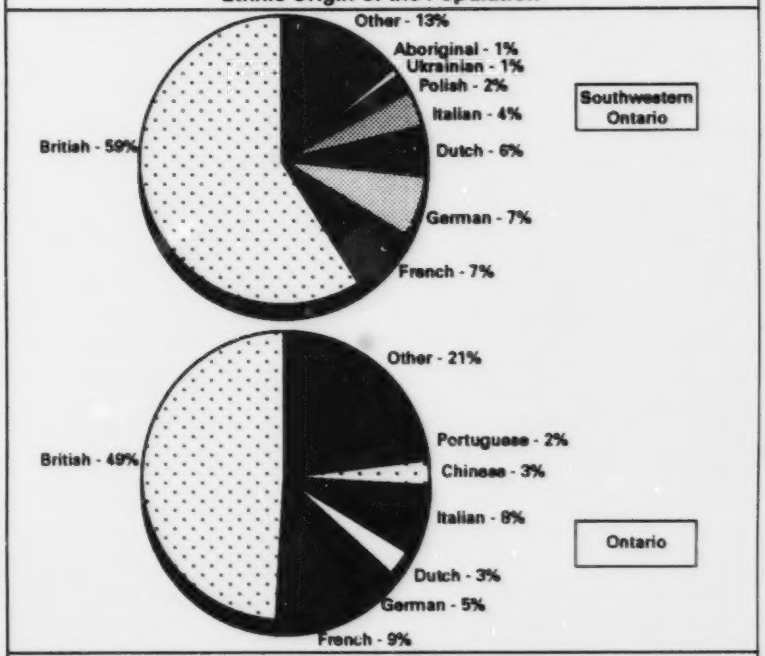
Aging of the population will have an impact on the health needs of Southwestern Ontario over the next ten years. Many previous studies have shown that people consume a disproportionate amount of health care and social services over the last several years of their lives. However, the impact of aging on the health care system will be a particular factor beyond the year 2001 and especially around 2015 when the "baby boom" population of the 1940s and 1950s reaches the age 65 and over.

Ethnic Origin

There are significant differences in the ethnic origins of the people of Southwestern Ontario compared with the people of Ontario as a whole. The percentage of people of British, German and Dutch origin is significantly higher than the entire Province, while the percentage of people of French and Italian origin is lower.

The patterns of ethnic origin by county show the presence of several significant groups throughout the Southwest Region. There are higher concentrations of people of French-origin in Essex (11 percent) and Kent Counties (7 percent) and people of German origin in Perth (13 percent), Bruce (10 percent) and Elgin Counties (7 percent) than in other counties. Oxford and Huron Counties have the highest proportions of Dutch origin (7.5 percent and 6.6 percent respectively), while Essex County has an Italian-origin population of 7 percent.

Ethnic Origin of the Population

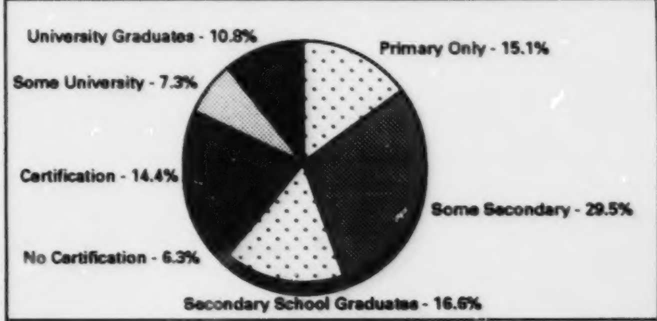


Source: 1986 Census

Level of Education

The pattern of education levels attained by the people of Southwestern Ontario is similar to that of people across Canada and in most other regions in the Province. Approximately 15 percent of people in the Region have less than a Grade 9 education, while close to 17 percent are secondary school graduates and 11 percent are university graduates. Within Southwestern Ontario, the highest level of education has been obtained in Middlesex County (12 percent are

Level of Education of the Population

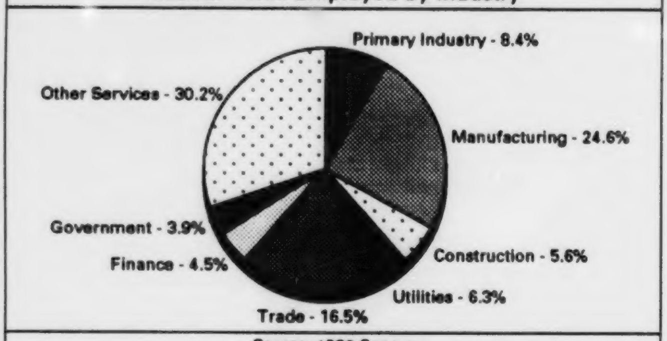


Source: 1986 Census

university graduates), while people in Elgin, Perth, Grey and Huron Counties have less formal education than those in the other counties.

Employment Patterns

Labour Force Employed by Industry



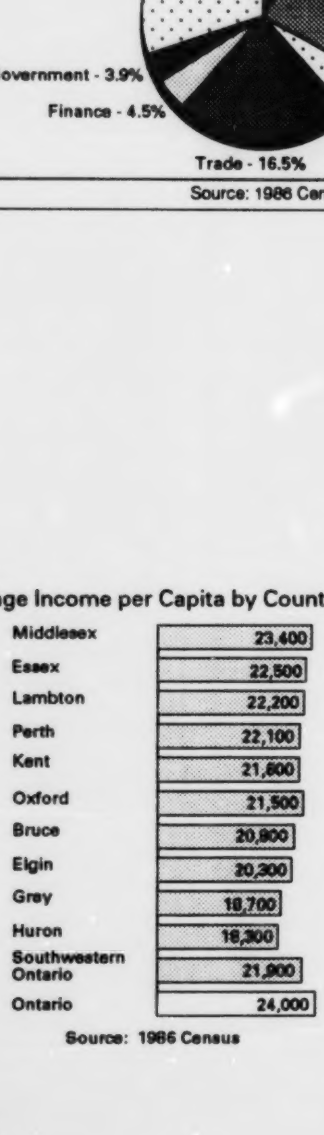
Source: 1986 Census

The pattern of labour force activities in Southwestern Ontario differs significantly from that of the entire Province of Ontario in one important respect. More than twice as many people are employed in primary industry (including farming) than in the Province as a whole. People in this industry are exposed to higher risks on a regular basis than people in other work settings, risks that are a significant contributing factor to health problems. The highest risk is in the Counties of Huron, Oxford, Perth and Bruce where 15 to 22 percent of the labour force works in primary industry.

The manufacturing sector, which employs almost 25 percent of the labour force, is the single, most significant employment sector in Southwestern Ontario. This sector, along with the construction sector, also presents higher risks from work-related hazards than other employment sectors.

Average Income

Average Income per Capita by County ($)



Source: 1986 Census

In 1985, the average income per capita in the Southwestern Region was almost $21,900, 9 percent below the Ontario average of $24,000. There was also a variation of 22 percent in average income levels within the Region, between a low of $18,300 in Huron County and a high of $23,400 in Middlesex. With the exception of Elgin County, per capita incomes are higher in the southern and more urbanized counties of the Region than those in the northern counties.

According to the 1986 Census, despite their relatively high average incomes, the Counties of Essex and Middlesex also have the highest incidence of low income families in the Region, together with Grey and Huron Counties. The incidence of low income in the remaining six counties is below that of the Province of Ontario as a whole. Adjusting for differences in age distribution, the proportion of Southwestern Ontario residents living in low income households is 17.8 percent higher than in the entire Province.

Unemployment

Unemployment rates in three counties in the Southwestern Region exceed the average for the Province of Ontario. The highest unemployment rate within the Region is in Essex, Lambton and Kent Counties. The County of Essex also has the highest percentage of its work force in the manufacturing sector (31.9 percent) and is highly dependent upon the automotive industry which is one of the most severely impacted sectors during times of economic recession. The unemployment rate in Windsor is currently at 13.4 percent.

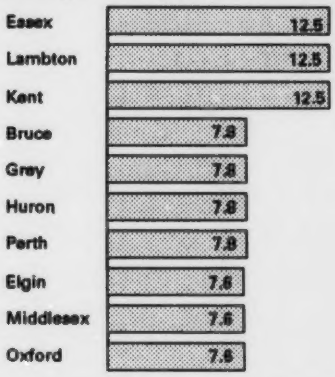
Unemployment rates in the remaining counties are below the average unemployment rate for the entire Province of Ontario. The City of London has an unemployment rate of 6.7 percent. The unemployment rate for females is higher than for males in all ten counties.

Family Size, Structure, and Living Arrangements

Family size in Southwestern Ontario ranges from 3.1 to 3.4 persons per family including 1.2 to 1.5 children per family. Family size in the Region is not significantly different from that in the entire Province.

With the exception of Essex and Middlesex, there is a slightly higher percentage of two-parent families throughout Southwestern Ontario than the provincial average of 88 percent.

The large majority of people in Southwestern Ontario (98.3 percent) live in private households while a small percentage (1.7 percent) live in collective dwellings such as hospitals, religious institutions, and penal institutions. Only 8.1 percent of the total population lives alone.



Percentage Unemployment May 1991

Source: Ministry of Treasury and Economics

Socio-Economic Profile

Of those persons aged 65 years or older, 91.0 percent live in private households (almost one-third of these people live alone) and 8.6 percent live in hospitals, institutions, and nursing homes or homes for-the-aged.

OUR HEALTH NEEDS AND PRIORITIES: IMPROVING HEALTH FOR ALL

Summary

The people of Southwestern Ontario enjoy a health status which is equal to or better than that of people in most countries around the world. Although limited data exists with respect to the level of people's health, it is possible to draw some conclusions concerning health status using standardized mortality rates. Based on an assessment of past trends and future projections in mortality rates, the health of the people in the Region can be improved in several respects.

Coronary heart disease and cancer are the two most prevalent causes of death in Southwestern Ontario. Together, they account for more than 70 percent of all deaths in the Region.

Overall, there are no significant differences in mortality rates among the ten counties which make up the Region. However, there is a higher incidence of death due to coronary heart disease, lung cancer and chronic obstructive lung disease and of suicide in certain counties.

Average mortality rates among both females and males are somewhat higher in Southwestern Ontario than in the rest of the Province. Higher mortality rates due to perinatal conditions (problems associated with birth), motor vehicle accidents, coronary heart disease and some cancers among females and males in particular age groups, are the major reasons for the overall differences in mortality between the Region and the Province. At the same time, it should be noted that mortality rates in Southwestern Ontario are lower than the rates in the rest of Ontario for certain age groups and with respect to some causes of death such as certain cancers and types of injuries.

Over the next ten years, significant changes in mortality rates from certain diseases are expected in Southwestern Ontario. For example, mortality rates from cerebrovascular disease (stroke), lung cancer and accidental falls are expected to increase among females. Mortality rates for both females and males are expected to increase due to most types of cancer, mental disorders, nervous system disease associated

with aging and perinatal conditions. Mortality rates for coronary heart disease and injuries and suicides are expected to decline for both females and males.

The patterns in mortality rates in Southwestern Ontario underscore the need to address such health-related factors as the environment, lifestyles, and transportation safety as part of a comprehensive strategy for improving the health of people in the Region.

OUR HEALTH NEEDS AND PRIORITIES: IMPROVING HEALTH FOR ALL

Mortality Patterns

Introduction

Overall, the health of the people of Southwestern Ontario is equal or superior to that of people in most countries around the world. This health status is due in large part to the effectiveness of the health care system, as well as to government policies with respect to such important health-related factors as the environment, the workplace and transportation system safety.

However, comparisons with other jurisdictions are only one means of assessing health status. Such comparisons do not necessarily reflect the health needs of the population. Despite the current relatively high level of health status of people within the Region, there is the need to reduce the incidence of illness and injury in a number of areas. Thousands of people in Southwestern Ontario die each year from disease and injury and many times this number require health care services to prevent, diagnose, and treat illness and injury.

Historically, there has been a lack of information to assess the health of the population and develop specific initiatives to improve health status. Until recently, health care providers have had to rely on data from Statistics Canada which, although useful, has not been collected for the specific purpose of assessing people's health in its broadest terms. In early 1990, the Ontario Government undertook the Ontario Health Survey, which represents a new initiative to identify health status and public attitudes toward health in each region of the Province in a more comprehensive and in-depth manner than has been done in the past. The results from the Ontario Health Survey are expected to be available in early 1992.

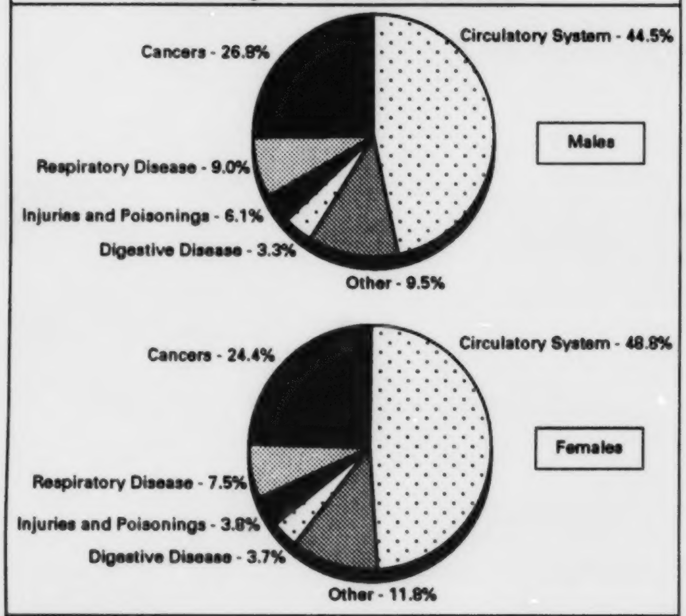
Although there are many possible indicators of health status, mortality is one measure which serves to identify existing health issues. According to a recent review of literature relating to needs-based health planning, the Standardized Mortality Rate appears to come closest to meeting the required characteristics as an indicator or proxy-measure of health-care need ("Needs-Based Planning of Health Care, A Critical Appraisal of The Literature", by Stephen Birch and John Eyles, 1990).

OUR HEALTH NEEDS AND PRIORITIES: IMPROVING HEALTH FOR ALL

Mortality Patterns

Despite its limitations, the existing data on mortality patterns shows that there are a number of significant health problems experienced by people within the Southwest Region. The analysis which follows focuses on the major causes of death and the most significant reasons for the higher incidence of death among the people in Southwestern Ontario compared to those people in the rest of the Province. (This material has been extracted from a report entitled "Disease-Specific Mortality Trends In Southwestern Ontario", by Robert J. Alder and Stephanie R. Loomer, 1991.)

Leading Causes of Death in 1988



Source: Statistics Canada

Leading Causes of Death

For the population overall, close to one-half of all deaths in Southwestern Ontario are due to circulatory system disease, including coronary heart disease, stroke and other forms of heart disease. The second leading cause of death relates to cancerous tumours. Among males, the most frequent kinds of cancers leading to death include throat and lung, colorectal, prostatic, lymphatic and hematopoietic tissue and bladder/urinary. Breast, colorectal, throat and lung, lymphatic and hematopoietic and pancreatic cancers are the most frequent among females. Together, circulatory system disease and cancers account for more than 70 percent of all deaths in the Region.

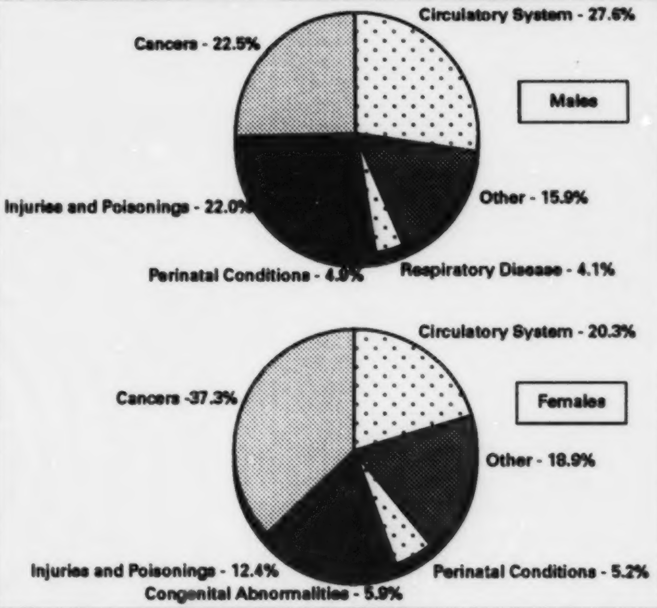
The third most frequent cause of death among males and females is respiratory disease, including chronic obstructive lung disease such as asthma, emphysema and chronic bronchitis, and pneumonia. Injuries and poisonings, which include motor vehicle traffic accidents, falls and suicides, account for the fourth highest number of deaths among both males and females.

Mortality Patterns

Lost Years from Premature Death

When mortality statistics are considered from the perspective of the number of years of life lost from average life expectancy, they present a somewhat different pattern. Circulatory system disease ranks as the highest contributor to the total number of lost years among males. However, since circulatory system disease occurs usually at an older age, it accounts for a significantly lower portion of the lost years compared to its share of total deaths in the Region. Cancers are the highest contributor to lost years among females, due in large part to the earlier incidence of tumours in comparison with circulatory system disease. Injuries and poisonings, particularly motor vehicle accidents and suicides, are more significant contributors in terms of lost years among both females and males than they are in relation to number of deaths. Perinatal conditions, including respiratory disease and short gestation, which result in premature death close to birth, are a significant contributing factor to lost years in both males and females as are congenital abnormalities (irregularities acquired before birth) among females.

Leading Causes of Potential Years of Life Lost in 1988



Source: Statistics Canada

Leading Causes of Death by Age Group

Females

The major causes of death among females in Southwestern Ontario vary according to age group. Perinatal conditions and congenital abnormalities

Leading Causes of Death by Age Group Among Females in 1988

Age Group (Years)	Total Number of Deaths in Age Group	Most Frequent Causes of Death	Proportion of Deaths in Age Group (%)
Less than 1	56	Perinatal Conditions Congenital Abnormalities	42.9 33.9
1 - 9	21	Injuries and Poisonings Congenital Abnormalities	42.9 19.0
10 - 19	29	Injuries and Poisonings Cancers	51.8 13.8
20 - 39	101	Injuries and Poisonings Cancers	33.7 33.7
40 - 64	740	Cancers Circulatory System Disease	51.2 26.1
65 and Over	4,313	Circulatory System Disease Cancers	54.8 19.9

Source: Statistics Canada

account for more than three-quarters of all infant deaths in the Region. Injuries and poisonings are the major cause of death for females between the ages of 1 and 19 years. However, cancers become a more significant cause in the age range of 10 to 19 years and are the dominating factor until females reach an elderly age. The leading cause of death among elderly females is circulatory system disease.

Leading Causes of Death by Age Group Among Males in 1988

Age Group (Years)	Total Number of Deaths in Age Group	Most Frequent Causes of Death	Proportion of Deaths in Age Group (%)
Less than 1	81	Perinatal Conditions Congenital Abnormalities	46.9 29.6
1 - 9	21	Injuries and Poisonings Congenital Abnormalities	47.6 14.3
10 - 19	51	Injuries and Poisonings Cancers	80.4 5.9
20 - 39	252	Injuries and Poisonings Cancers	64.3 10.9
40 - 64	1,250	Circulatory System Disease Cancers	38.6 37.7
65 and Over	4,410	Circulatory System Disease Cancers	49.7 25.5

Source: Statistics Canada

Males

The patterns of death among males differ from females in two respects. Injuries and poisonings account for a much higher percentage of deaths, while cancers are a less significant contributing factor in the middle years of life but more important after the age of 65.

Leading Causes of Death by County

Overall, the mortality patterns in 1988 indicate that there are no significant differences in mortality rates (the total number of deaths per 100,000 population) among the ten counties within Southwestern Ontario. However, there are several differences in the proportion of deaths from certain causes. For example, it appears that coronary heart disease contributes to a higher death rate among both males and females in the southern counties of Lambton, Kent and Essex, than in the rest of the Region. Lung cancer mortality rates are the highest among males in Kent and Elgin Counties. Chronic obstructive lung disease among males and females is most prevalent in Oxford County. Suicide rates are the highest among males in Bruce and Grey Counties and among females in Kent and Elgin Counties.

OUR HEALTH NEEDS AND PRIORITIES: IMPROVING HEALTH FOR ALL

Mortality Patterns

There have been many studies in jurisdictions around the world which have linked the incidence of death to certain causes. However, the reasons for the mortality patterns in Southwestern Ontario are difficult to determine and can be subject to considerable interpretation and debate. The most important linkage identified by previous studies is the impact of diet and smoking on the incidence of disease and death due to heart disease and cancer. Other studies have shown that economic hardship and the lack of social supports are contributing factors to the incidence of suicides.

Comparison of Mortality Rates Between The Southwest Region and Ontario

Females

When all age groups are considered together, mortality rate among females in Southwestern Ontario due to all causes are 5 percent higher than for females in the rest of Ontario. However, there are significant variations in comparative death rates for females by age-group. There is a lower incidence of death among females between the ages of 1 and 9 and 20 and 39 while more females die in Southwestern Ontario than in the rest of the Province in other age categories. The largest difference between mortality rates in Southwestern Ontario and the Province is for females between the ages of 10 and 19. The single most significant factor, which accounts for a 20 percent higher mortality rate in Southwestern Ontario than in the rest of the Province, is motor vehicle accidents.

Comparison of Death Rates by Age Group Among Females in 1988

Age Group (Years)	Ratio of Total Deaths in Southwestern Ontario to Ontario (Rate)	Most Significant Cause of Higher Deaths in Southwestern Ontario (Cause)	(Rate)
Less than 1	1.10	Perinatal Conditions	1.22
1 - 9	0.88	Motor Vehicle Accidents	1.09
10 - 19	1.21	Motor Vehicle Accidents	1.20
20 - 39	0.89	Nervous System Diseases	1.80
40 - 64	1.08	Coronary Heart Disease	1.22
		Throat and Lung Cancer	1.10
		Colorectal Cancer	1.19
65 and Over	1.05	Coronary Heart Disease	1.22
		Colorectal Cancer	1.12
		Diabetes	1.23
All Ages	1.05	Coronary Heart Disease	1.22
		Colorectal Cancer	1.45
		Diabetes	1.26

Source: Statistics Canada

OUR HEALTH NEEDS AND PRIORITIES: IMPROVING HEALTH FOR ALL

Mortality Patterns

Despite the overall favourable comparisons in the 1 to 9 and 20 to 39 age groups, there is a higher incidence of death among females in these groups in Southwestern Ontario due to particular causes such as motor vehicle accidents and nervous system diseases.

The other significant higher death rates in the Region compared with the rest of Ontario are due to perinatal conditions among female infants, coronary heart disease and colorectal cancer for females who are 40 years and over, throat and lung cancer for females between the ages of 40 and 65, and diabetes for females over 65.

Comparison of Death Rates By Age Group Among Males in 1988

Age Group (Years)	Ratio of Total Deaths in Southwestern Ontario to Ontario (Rate)	Most Significant Cause of Higher Deaths In Southwestern Ontario (Cause)	(Rate)
Less than 1	1.16	Perinatal Conditions	1.42
1 - 9	0.76	Motor Vehicle Accidents	1.29
10 - 19	1.05	Motor Vehicle Accidents	1.34
20 - 39	0.96	Motor Vehicle Accidents	1.28
40 - 64	1.05	Coronary Heart Disease	1.16
		Throat and Lung Cancer	1.26
		Colorectal Cancer	1.40
65 and Over	1.10	Coronary Heart Disease	1.23
		Prostatic Cancer	1.24
		Bladder and Urinary Cancer	1.31
		Stomach Cancer	1.19
		Chronic Obstructive Lung Disease	1.17
All Ages	1.08	Coronary Heart Disease	1.22
		Colorectal Cancer	1.15
		Prostatic Cancer	1.21
		Chronic Obstructive Lung Disease	1.16

Source: Statistics Canada

Males

The mortality rate among males of all ages is 8 percent higher in Southwestern Ontario than in the rest of the Province. The most significant difference in mortality rates is for male infants. Males in Southwestern Ontario under the age of one year have a 16 percent higher mortality rate than males outside of the Region. The largest contributing factor to this difference relates to perinatal conditions which result in a 42 percent higher death rate in Southwestern Ontario than in the rest of the Province.

Although males in the Region between the ages of 1 and 9 years and 20 to 39 years have lower overall mortality rates than their counterparts in the rest of the Province, there is a higher incidence of death among Southwestern Ontario males between the ages of 1 and 39 years from motor vehicle accidents.

The other most significant higher death rates among males in the Region compared to the rest of the Province are due to coronary heart disease among males 40 years and over, throat, lung and colorectal cancer for males between the ages of 40 and 64, and prostatic, bladder, urinary and stomach cancer and chronic and obstructive lung disease for males who are 65 years and over.

Trends in Mortality Rates

Introduction

Trends in the mortality rates between 1951 and 1988 for males and females in Southwestern Ontario were examined for the major causes of death. Regression analysis was used to estimate the trends in the incidence of these diseases over the next ten years.

Circulatory System Disease

Between 1951 and 1988, the incidence of mortality from coronary heart disease fell by 4.6 percent among females and by 34 percent among males in Southwestern Ontario. Using regression analysis, mortality rates from coronary heart disease for both females and males are expected to continue to fall to the year 2001. However, the trend in mortality from cerebrovascular disease among women is expected to increase over the next ten years to almost double the actual rate in 1988.

Cancer

Lung cancer mortality among males and females in the Region increased dramatically between 1951 and 1988. Future mortality rates from lung cancer are expected to fall for males but to increase exponentially among females, overtaking breast cancer as the leading cause of cancer deaths among females by 1995.

With the exception of lymphatic and hematopoietic cancer in males and colorectal cancer in females, mortality rates for all other leading cancer sites are expected to increase by some degree through the 1990s.

"It is anticipated that within the next ten years, the number of new cancer patients to the Canadian Regional Cancer Centre will increase by 50 percent due to the increase in aging population."

London Regional Cancer Centre
Commission Public Consultation Process
October to November 1990

Respiratory Disease

Mortality rates from chronic obstructive lung disease, a disease which is often associated with smoking and air pollutants, have increased consistently since the late 1950s among both females and males. The mortality rate among males is expected to plateau in the 1990s for males and at the turn of the century for females.

Injuries and Poisonings

The incidence of death from motor vehicle accidents has declined by one-half among males since 1972, and among females since 1965, due largely to the enforcement of stricter alcohol usage laws, seat belt and motorcycle helmet legislation and speed limits. Future mortality rates from motor vehicle accidents are expected to drop sharply.

The declining mortality rates from accidental falls which have taken place over the past three decades are projected to continue through the 1990s for males but, among females, this trend, which levelled off in the early 1980s, is expected to be reversed.

Suicide in Southwestern Ontario is projected to decline through the 1990s in both males and females.

Mental Disorders

Between 1960 and 1988, mortality rates in Southwestern Ontario due to mental disorders increased by more than 200 percent for both males and females, with a somewhat higher increase among males. Despite a projected decrease in suicides, these trends are expected to continue over the next ten years.

Nervous System Disease

Between 1979 and 1988, a sharp increase in mortality attributed to Alzheimer's disease occurred among males and females in Southwestern Ontario. Nervous system disease associated with aging is projected to increase by 126 percent in males and 144 percent in females by the year 2001.

Perinatal Conditions

Mortality due to perinatal conditions declined in Southwestern Ontario between the early 1950s and the early 1980s and levelled off during the late 1980s. An upturn in mortality rates among both females and males is expected through the 1990s primarily due to an expected increase in the successful delivery of premature infants which, while made possible through advancements in medical practice and technology, also presents a higher risk of death from complicating factors such as respiratory disease.

Health Imperatives

The historical and projected mortality patterns indicate that there are some serious issues with respect to the health status of the people of Southwestern Ontario. It is possible to speculate at length as to the specific reasons why these patterns are occurring. More important is the need to develop more comprehensive measures of health status, conduct further research and evaluation into the underlying causes for these patterns and undertake initiatives to improve the health of people at risk in these situations.

OUR HEALTH NEEDS AND PRIORITIES: IMPROVING HEALTH FOR ALL

Summary

The priorities for improved health in Southwestern Ontario are based on the vision of health and long-term goals established by the Premier's Council on Health Strategy. These address, not only the manner in which services are provided by the health care system, but also the broad determinants of health including socio-economic factors, the environment, and individual lifestyles.

Over the next ten years, continued population growth and aging of the population will generate increased needs for health services in Southwestern Ontario. However, the elimination of disparities in health status among economically, socially, and culturally disadvantaged groups will also need to be given a high priority in order to achieve better health for all people in the Region. Programs for addressing these disparities will need to encompass social, economic, and environmental measures as well as initiatives in the health care system.

Diseases such as coronary heart disease and certain cancers which are more common in Southwestern Ontario compared with the rest of Ontario, will also need to be addressed.

While the treatment of illness and injury will continue to be a major part of the health care system, the role of health promotion and disease prevention programs will need to be greater than it has been in the past.

In order to improve health and help reduce demands on the health care system, members of the public will need to take a more proactive role in managing their own lifestyles and in the appropriate use of the health system. Increased emphasis on public education in health promotion and disease prevention will be needed to support and empower the public in the achievement of improved health.

OUR HEALTH NEEDS AND PRIORITIES: IMPROVING HEALTH FOR ALL

A Vision of Health

A Broad View of Health

Over the past ten years or more, the definition of health, the factors which influence the degree to which good health can be achieved, and the strategies for improving health have undergone a radical and fundamental change in many countries around the world. Health is no longer regarded as the domain of the health system alone. The creation and distribution of a nation's wealth, the development of healthy public policies with respect to the environment and the work place, and individual lifestyles are all significant determinants of good health. Through public education and the media, people within Southwestern Ontario are becoming more aware of this broader view of health and of the need to address a wide range of issues in any effort to improve health status.

In 1987, the Premier's Council on Health Strategy was established by the Premier of Ontario with the mandate to "provide leadership and guidance to the whole government in achieving the goal of health for every citizen in Ontario". In its first report, the Council proposed the following vision of health which embodies the three concepts of the broad determinants of health, individual responsibility for health, and the responsibility of government to provide equitable access to health.

> *"We see a society in which people live in good health, and disease and disability are progressively reduced. We see people empowered to realize their full potential through a safe, non-violent environment, adequate income, housing, food and education, and a valued role to play in family, work and the community. We see people having equitable access to affordable and appropriate health care regardless of geography, income, age, gender or cultural background. Finally, we see everyone working together to achieve better health for all."*
> Premier's Council On Health Strategy

This vision will become the focus of efforts toward improving the health of the people in Southwestern Ontario. The achievement of improved health will require a common understanding of this vision.

OUR HEALTH NEEDS AND PRIORITIES: IMPROVING HEALTH FOR ALL

A Vision of Health

Collective action is needed which involves not only members of the public and service providers from within the health care system, but also individuals from other fields such as local government, education, housing, transportation and the environment.

Health Goals for Southwestern Ontario

In the past, the relationship between good health and factors such as income, public policy and individual lifestyles, while recognized, have not been approached through any formal or integrated framework for improving health. In Ontario, beginning with the Premier's Council, an effort has been underway to establish more direct linkages among the broad determinants of health through the development of specific goals, objectives and targets for improved health. The Premier's Council has laid the groundwork for people across the Province to develop and implement strategies for improving health which relate to the specific needs and priorities within their own areas. The goals for the improvement of health established by the Premier's Council will provide the basis for establishing the health priorities for the people of Southwestern Ontario. These goals are as follows:

- shift the emphasis to health promotion and disease prevention;
- foster strong and supportive families and communities;
- ensure a safe, high quality physical environment;
- increase the number of years of good health for the citizens of Ontario by reducing illness, disability and premature death, and
- provide accessible and appropriate health services for all.

The Premier's Council has established specific objectives and targets for the second, third, and fourth of these goals and is in the process of completing this task for the remaining goals. The objectives and targets developed by the Premier's Council will be incorporated into the development of strategies for improving health in Southwestern Ontario.

OUR HEALTH NEEDS AND PRIORITIES: IMPROVING HEALTH FOR ALL

Future Health Needs

HEALTH PRIORITIES FOR 2001

Introduction

One of the founding principles of Canada's national health system is the provision of accessible and affordable health services for all people. In applying the vision and goals to the future health needs for Southwestern Ontario, it is necessary to focus on those groups of people which, by reason of demographic changes, socio-economic disparities, an above average risk of contacting particular diseases, or difficulties in gaining access to health care services, require a focussed effort to improve their health status. In this way, the health status of the entire population can be improved in a manner which is consistent with the long-term health goals for the region.

Demographic Needs

Population Growth

With total population growth which is expected to be less than 1 percent per year between 1991 and 2001, there will be a relatively modest increase in the total service demands in the Region. In terms of visits to doctors and nurses and overnight stays in hospitals, nursing homes and convalescent homes, it is estimated that the increased size of the population will create additional service demands of approximately 0.9 to 1.2 percent per year to the year 2001. Based on the population projections by county, the increased demands will be most significant in Essex and Middlesex Counties followed by Elgin, Grey and Kent.

Aging of the Population

Various studies have shown that people place the most demands upon the health system during the last years of their lives. Over the next ten years, the population in the region will experience relatively modest growth in the number of people over the age of 65 in comparison with the aging which will occur in the first fifteen years of the next century as the impacts of the "baby boom" of the 1940s and 1950s are experienced and the demands of the elderly for health services become massive. This pattern of aging of the population provides a "window of opportunity" in the 1990s to address other health priorities before the need to accommodate the major increase in demand for elderly care becomes acute in the next century.

Pattern of Urbanization

A large percentage of the population of the Southwest Region will remain in rural settings over the next ten years. People in these situations are more difficult to serve effectively and efficiently compared with urbanized populations, due to their sparsely distributed populations. The needs of people in rural settings throughout the Region will continue to be difficult to serve, particularly in the Counties of Bruce, Huron and Perth which will experience little or no population growth over the next ten years.

Disparities in Health

Disparities in health status and in access to the health system among different societal groups due to social, economic, cultural, and environmental factors have been studied in the past. (See "Nurturing Health, A framework on the Determinants of Health", Premier's Council on Health Strategy, 1991). Over the next ten years, a number of such disparities throughout Southwestern Ontario will need to be addressed.

For example, the incidence of lower income and single-parent families and unemployment is higher in certain parts of the Region than for the Province as a whole. Evidence from previous studies as well as the Premier's Council shows that people in these circumstances experience more health-related problems than the average person, often due to related stress, diet and other lifestyle factors.

By virtue of their ethnic origin and culture, certain groups within the total population of Southwestern Ontario face special health issues and problems. First, as described during the public consultations, language barriers create difficulties in gaining access to appropriate health services for first-generation Canadians in some groups such as the Low German-Speaking Community. The capability to provide health services in the French language in designated areas under the French Language Services Act of Ontario must also be ensured.

In addition to language barriers, some ethnic groups have a higher than average incidence of health problems due to such factors as cultural background, economic status, or their inherited predisposition to certain diseases. For example, the special needs of Aboriginal Peoples will need to be addressed.

The higher percentage of the workforce employed in the primary sector in Southwestern Ontario than in the rest of Ontario also presents a greater risk to accidental injury and death in the workplace than in other regions in the Province.

In addition to making improvements to the health care system, future efforts aimed at reducing disparities in health will need to encompass measures dealing with the social, economic, and environmental factors which are contributing to these problems.

Priorities for Disease Prevention

The historical mortality patterns among residents of Southwestern Ontario point to several problem areas which need to be addressed. Some of these patterns are similar to other regions in the Province and, by virtue of their historical significance, have been given a high priority in the past.

However, in the future, increased emphasis will be needed to reduce health problems which are more prevalent in Southwestern Ontario than in the rest of the Province. Some of these problems, including coronary heart disease and certain cancers, have been identified in the previous chapter. A more concerted and comprehensive effort is required in order to identify the causes and reduce the incidence of these diseases in Southwestern Ontario.

Health Promotion and Disease Prevention

Historically, the role of health promotion and disease prevention within the total health care system has been a minor one. Emphasis has been placed on the cure or treatment of illness or injury, with a negligible amount of health system funding allocated to the prevention of disease and the promotion of good health. In the future, as now, the care of the most intensely ill people will continue to be a central role of the health care system, one that consumes the lion's share of resources. However, a more significant and concerted effort will have to be placed on health promotion and disease prevention if the goals for improved health are to be achieved in Southwestern Ontario. This effort must be directed toward improvements in the broad determinants of health through the coordination of programs and resources which address relevant health, social, environmental, educational, and economic issues.

The Role of the Individual

Healthy Lifestyles

Central to the broad concept of health is the role of the individual. The link between a healthy lifestyle – proper nutrition, exercise, reasonable levels of stress, the avoidance of harmful substances – and good health, is now a proven and widely recognized fact. Lung cancer and heart disease are two of the most commonly known health problems which are often related to unhealthy lifestyles, particularly to smoking tobacco.

Individuals can play a major role in maintaining and improving their own health and reducing the demands on the health system. Although the long-term impacts of healthier lifestyles on the costs of health care, especially in the last few years of life have not been clearly documented, it is apparent that, during most of a person's lifetime, the demands on the health system for treatment from disease or accidental injury can be reduced and the quality of life and health of the individual improved. People have a tremendous potential to achieve better health and play a significant role in managing the health system through better management of their own lifestyles. However, they will not be able to do so entirely on their own, without support and education.

While individual lifestyle can be linked directly to illness in many cases, there are many health problems throughout Southwestern Ontario which are somewhat beyond the ability of the individual to influence or control. For example, many forms of heart disease and cancer appear to be linked more to family history or to the quality of the environment than to individual lifestyles. In these instances, a healthy lifestyle can have only a partial effect through avoidance or prevention measures.

In these circumstances, collective action on the part of individuals can have a significant impact by encouraging the adoption of such measures as healthy public policies or educational programs. The role of the individual, in the form of collective action, is central to achieving improved health in situations where the health of an entire community or segment of the population needs to be improved.

Empowerment

An important health priority over the next ten years will be the empowerment of the people of Southwestern Ontario to play a major role, both collectively and as individuals, in the achievement of improved health in the Region. This must include participation in the development of strategies and plans for the health care system. Further research into the determinants of health and public education about how individuals can improve health will also be important tools in strengthening the role and responsibility of each individual in meeting the health priorities in Southwestern Ontario.

OUR HEALTH SYSTEM: THE NEED FOR NEW DIRECTIONS

OUR HEALTH SYSTEM: THE NEED FOR NEW DIRECTIONS

Summary

The provision of health care in Southwestern Ontario is made possible through a wide range of organizations and individuals.

The Provincial Government has the overall responsibility for funding and management of the health care system and for providing the framework for ensuring the provision of accessible, effective and affordable health services throughout the Region. Its mandate is carried out principally through the Ministries of Health and Community and Social Services. The Provincial Government manages and controls the allocation and flow of both operating and capital funds to individual health care service providers in the Region.

For almost two decades, District Health Councils have provided a forum for the public, service providers, and local government to plan and develop health and social services in a collaborative manner. There are five District Health Councils in the Southwest Region which encompass all areas with the exception of Huron and Perth Counties.

There is a wide array of service providers which, together, comprise a network of health care services in the Region. These service providers include physicians and other health professionals, public health units, ambulance services, community, teaching, chronic care and psychiatric hospitals, nursing homes and homes-for-the-aged, community and social service agencies, rest homes, child and family service organizations, other specialty service institutions and agencies, and many volunteers who donate their time directly or through various service provider organizations.

Universities and community colleges in the Region are responsible for the education of future health professionals and for undertaking research and scholarship efforts which can be applied to improving the standard of health care available to the people of Southwestern Ontario and to promoting and supporting change in the delivery of health care.

The Provincial Government

The Provincial Government has the overall responsibility for funding and management of the health care system throughout Ontario. Through legislation, government policy, and administration of the funding for service providers, it is responsible for establishing the framework for ensuring the provision of accessible, effective and affordable health care throughout the Province, including Southwestern Ontario.

Primarily, through the Ministries of Health and Community and Social Services, the Province provides leadership in meeting the changing needs of the population and in finding ways to preserve and enhance the health care system. For example, the Provincial Government has taken the lead role in increasing the emphasis on community services and health promotion and disease prevention. It has also taken steps to control the increasing costs of hospitals and has shown its intention to control the costs of physician services.

The Provincial Government also has the responsibility for approving plans for new programs and services and for contributing Provincial capital funds toward the expansion, upgrading, and renovation of health care facilities. The primary role of the Provincial Government is to achieve coordination and collaboration among health service providers.

From a strategic perspective, the Provincial Government oversees how the health care system will be developed and how operating and capital funds will be allocated among service providers. The Province is also a direct provider of some health care services. These include emergency services, health promotion, public laboratories, and psychiatric hospitals which are operated by the Ministry of Health; it also operates facilities for children and adults with emotional and developmental disabilities which are under the purview of the Ministry of Community and Social Services.

District Health Councils

District Health Councils were originally established by the Ontario Ministry of Health in 1973. They are composed of provincially-appointed representatives from local communities, including individual citizens, service providers, and representatives of local government.

The original mandate of District Health Councils was to:

- identify district health needs and consider alternate ways of meeting those needs;
- plan a comprehensive health care program and establish short-term priorities which are consistent with long-term goals;
- coordinate all health activities and ensure a balanced effective and economical service which is satisfactory to the community, and
- work toward cooperative efforts in social development activities for the district.

In 1989, the Ministry of Health endorsed an enhanced advisory role for District Health Councils in four areas, including allocation of funds, determination of human resource requirements in the health field, establishment of measures for strengthening area-wide planning, and achievement of integrated health and social services planning.

As local health planning and advisory bodies, District Health Councils provide a forum for the public, service providers, and Local Government to plan the development of health care services in a collaborative manner.

There are five District Health Councils in Southwestern Ontario including Essex, Grey-Bruce, Kent, Lambton, and Thames Valley (which includes Elgin, Middlesex, and Oxford Counties).

Service Providers

In Southwestern Ontario, there is a wide array of service providers, which together comprise a network of health care services. The large majority of these organizations are funded directly by the Provincial Government and operate on a quasi-independent basis through appointed boards of governors. Most physicians and other health care professionals, such as dentists and chiropractors, operate as solo practitioners, in group practices or with hospitals or other service providers.

The service providers in the Southwest Region, grouped by major category or type, are as follows;

- **Physicians**, including family physicians or general practitioners, specialists whose practices are concentrated in the conceptual disciplines (such as internal medicine, paediatrics, psychiatry, etc.) or procedural disciplines (such as surgery, obstetrics, etc.), and sub-specialists who practice in highly specialized fields (such as cardiovascular surgery, endocrinology, etc.);
- **Other Health Professionals**, such as nurses, physiotherapists, pharmacists, dentists, and psychologists. Currently, there are twenty-four health professions governed under the Regulated Health Professions Act;
- **Public Health Units,** which provide public health programs and services in community sanitation, control of communicable disease, family health, home care, preventive dentistry, and public health education in each municipality. These units are governed by appointed boards of health and are jointly funded by, and responsible to, Local and Provincial Government;
- **Ambulance Services,** which are operated directly by the Ministry of Health or through hospitals, other not-for-profit agencies or the private sector;
- **Community Hospitals,** which provide care or treatment for illness or injury, involving the concentrated efforts of health care practitioners of several disciplines. Some of these hospitals also provide chronic or long-term care;

Service Providers

- **Teaching Hospitals of the Health Sciences Complex,** which, in addition to offering the same services as acute care community hospitals, provide more complex and specialized acute care services for residents both within and beyond the Region, as well as acting as regional, provincial, and national focal points for the education of health professionals and health research;
- **Chronic Care Hospitals,** which specialize in the provision of long-term care and rehabilitation for people suffering from chronic illness associated with aging or injury;
- **Psychiatric Hospitals,** which provide acute and long-term care for those suffering from mental disease;
- **Nursing Homes and Homes-for-the-Aged,** which provide supportive living accommodation for the elderly including nursing and other support services where needed;
- **Community Service Agencies**, including a wide range of organizations such as Home Care, Placement Coordination Services for the elderly, Victorian Order of Nurses, and the Red Cross;
- **Rest Homes,** which provide supportive living accommodation for the elderly;
- **Child and Family Service Organizations,** including children's mental health centres, children's aid societies, centres for the emotionally and developmentally disabled, and other agencies;
- **Other Institutions, Group Homes and Hospitals**, which provide specialty services for particular groups such as the hearing impaired and the emotionally impaired, and
- **Volunteers,** who donate their time and expertise as representatives on service provider boards and coordinating bodies (such as District Health Councils) and provide assistance and support for recipients of health care. Without the dedication and commitment of many volunteers, the health system could not function.

Service Providers

In order to foster collaborative efforts and cooperation among service providers, various planning and coordinating bodies have been established.

Educational and Research Institutions

The education of future health professionals is the responsibility of the universities and colleges in Southwestern Ontario. Much of this responsibility is concentrated in the University of Western Ontario and particularly in the Health Professional Faculties and Schools which, together with the three London teaching hospitals, constitute the Health Sciences Complex. The University of Windsor and Fanshawe, St. Clair and Georgian Community Colleges also play important roles in the education of health professionals.

Through the education of future health professionals, clinical research and scholarship programs, educational institutions in the Region play an important role in promoting and supporting advancements in the delivery of health care.

It is in these environments that research and scholarship are conducted by faculty members who have particular responsibilities to ensure that the results are made available both to students and to those already practising in the health professions. Through the application of the results of research and scholarship, continuous qualitative improvement is achieved in the standard of health care available to the people of Southwestern Ontario and elsewhere.

OUR HEALTH SYSTEM: THE NEED FOR NEW DIRECTIONS

Summary

The people of Southwestern Ontario enjoy the benefits of one of the best health systems in the world. However, concerns raised by citizens and representatives of service providers during the public consultations indicate that there are many issues that need to be addressed with respect to the availability, quality, and appropriateness of health services throughout the Region.

From an overall perspective, there are several, major strategic issues which need to be addressed in order to meet the health system needs and priorities of the people of Southwestern Ontario to the year 2001.

The governance of the health care system needs to be responsive to community health needs and to involve people to a more significant degree in making decisions which have an impact on their health and well-being. The Provincial Government policy to contain the growth in health care spending across the Province means that the costs of the system must be better controlled in the future than in the past.

Within this context, the Region cannot afford to continue its present emphasis on institutional services. A more appropriate balance between institutional and community-based and in-home support services is required to control the growth in costs and to deliver the most appropriate health care to people in their own homes. The capability of selected community hospitals to deliver secondary care needs to be enhanced in order to meet the institutional health needs of the individual as close to home as possible and in a cost effective manner. Coordinating mechanisms are required to address the broad range of health, social, environmental, and economic issues which impact the health status of any particular group of the population.

Long-term planning and facilities development need to become more integrated among individual service providers. Capital spending needs to be more closely linked with increasing operating efficiency and reducing the operating costs of service providers.

Responsibility and Accountability

Currently, the Provincial Government, primarily through the Ministry of Health, is responsible for funding and overall management of the health care system in Ontario. It is accountable to the Provincial Legislature, which represents the citizens of this Province. Major decisions with respect to the functioning of the health care system and the provision of health services are made on a centralized basis and applied throughout Ontario. Policies, standards, financial plans and actions of the Provincial Government must attempt to meet the wide range of health needs and circumstances which exist in various regions across the Province. Under this system, it is often difficult to develop and implement policies which meet the different needs in each region while maintaining acceptable standards of health care within the limits of available financial resources.

It is clear from the Commission's public consultation process, that both the public and service providers in Southwestern Ontario believe that the health care system needs to respond to local needs and that people need to be more involved in decisions which affect the nature, availability and quality of health services available to them. Consistent with these views, and based on the experience of other jurisdictions, the Premier's Council on Health Strategy identified in its March 1991 report, "Local Decision Making For: Health and Social Services", the potential strategy for the Provincial Government to work toward devolving responsibility for the allocation of health and social service budgets and planning, management, coordination and evaluation of services to a regional level throughout the Province.

When it comes to the provision of health care services, Southwestern Ontario is a distinct and self-sufficient geographic area. For example, according to the Ministry of Health data, in 1991 the total estimated hospital referral population (total population served) was 1.6 percent greater than the total population in Southwestern Ontario, which represents a minor net migration of people from other jurisdictions to the Region for health care services. By virtue of the fact that the Region contains a health sciences complex, with the exception of a very few highly specialized services, virtually all hospital services received by the people in Southwestern Ontario are provided from within the geographic area.

The size and relative self-sufficiency of Southwestern Ontario with respect to the delivery of health services provide the opportunity to devolve much of the responsibility for the governance of the health care system from the Ministry of Health to a regional body responsible and jointly accountable to the Government of Ontario and to the people in the Region. At the same time, there is a need to maintain consistent, Province-wide standards for the delivery of health care. These standards need to be developed with input from both the central government authority and local communities.

Planning

Historically, health programs and services have been planned and developed by individual service providers within the context of their own defined roles and responsibilities and service delivery methods. In the future, service providers will need to focus on meeting more broadly defined health needs. Increased collaboration among service providers and input from the public will be required in order to plan and establish comprehensive health services which best meet local needs. In this way, the most important health priorities of local communities can be identified and the best methods of service delivery established within the Province-wide guidelines and standards which are necessary to ensure the equity of access to the health care system.

Human Resources Management

The quality, accessibility and cost effectiveness of health services depend directly on the availability of properly trained and experienced people throughout the health system. Human resources are also the single most costly element in the delivery of health care. Furthermore, predicting and meeting the needs for health professionals, para-professionals and allied health workers is a difficult and complex task.

Currently, the needs for human resources are determined by individual service providers and professional associations on a tactical, short-term basis but not in any coordinated manner for the longer term. There is a need to establish a more systematic process for managing human resources in Southwestern Ontario.

Information on the supply of, and demand for, human resources is limited and fragmented, making it difficult for individual organizations to plan for and meet their needs. It is also difficult to identify major, common issues with respect to shortages or surpluses in specific categories of human resources until these imbalances create significant problems in terms of the lack of availability of service or excessive costs in the system. In addition, the current approaches to human resources management would not support the achievement of strategic changes in the health care system. There is an opportunity to begin to manage human resources on a more integrated and coordinated basis throughout Southwestern Ontario.

Funding

The funding of health services throughout Ontario is governed through a top-down process from the Provincial Government. This process is fragmented at the local level and does not provide an effective framework for the reallocation of resources to meet regional and local health needs and priorities. The allocation of funds among institutions, community-based agencies and physicians, and between geographic areas and service providers within the Region needs to be better coordinated. A mechanism is required to make the allocation decisions and trade-offs needed to maintain health services while investing in priorities such as health promotion and health education and research. The opportunity exists to improve the effectiveness of the health care system through the creation of a funding system which is integrated, coordinated, and directed to achieve strategic goals and objectives at the Regional level.

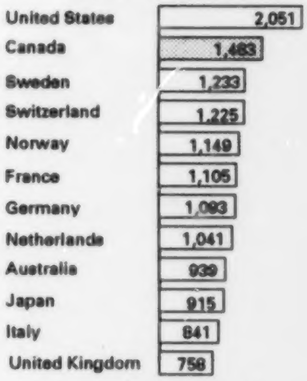
Historical Spending Patterns

Introduction

The existing health care system has been developed at a high cost to the beneficiaries of this system. With the exception of the United States, which does not have a national health system, and despite having a relatively small population over the age of sixty-five, per capita spending on health services in Canada is higher than any other industrialized country in the world. Next to the United States and Sweden, Canada devotes the highest percentage of its Gross Domestic Product to health care.

When Canada's national health system was established, the Federal and Provincial Governments entered into a 50/50 cost sharing agreement to fund the system. With the creation of the Established Programs Financing formula in 1977, a ceiling was established on the total amount of funding which the Federal Government provides to each Province for health care. This agreement has placed a greater reliance on the Provinces to manage and control their health care costs. With the rapid growth in spending on health services over the past fifteen years, the major part of the burden for financing the system has been transferred to the Provinces. With the passage in early 1991 of Bill 69, the Federal Government funding of health care will cease in 1997.

Comparison of Health Expenditures per Capita in 1987 ($)



Source: Ministry of Health

Growth in Total Spending

Health care expenditures in Ontario have been increasing at an alarming rate. Between 1980/81 and 1990/91, the average annual growth rate in total health care operating expenditures across the Province was 12.1 percent compared to an average annual population growth rate of 1.3 percent. Ignoring the effects of inflation the "real" average annual growth in health expenditures was 5.9 percent. Over this same period, health care spending rose from a share of 29 percent to 33 percent of total Provincial expenditures. Provincial expenditures on health care have risen to the point where there have been significant reductions in other government services.

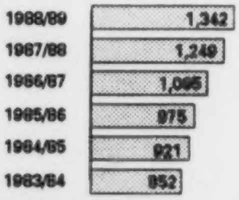
OUR HEALTH SYSTEM: THE NEED FOR NEW DIRECTIONS

Management of Health Care Expenditures

In Southwestern Ontario, the rate of growth in health care operating expenditures has been similar to that in the Province as a whole. Between 1983/84 and 1988/89, total operating expenditures on health services rose from $1.1 million to 1.8 million, an average annual growth rate of 10.3 percent. During this same period, the population of the Region increased by 42,500 or 3.3 percent. The combination of rapidly increasing costs and low population growth produced an average annual growth rate in per capita spending on health services of 9.6 percent.

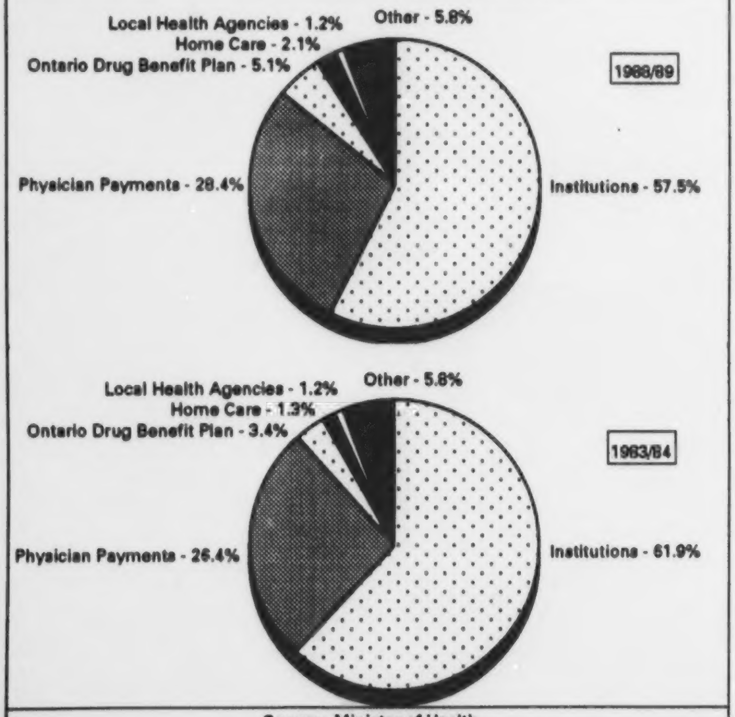
Between 1983/84 and 1988/89, total health care expenditures per capita in Southwestern Ontario were somewhat higher than the Provincial average. In 1988/89, the total per capita spending on health care in Southwestern Ontario was $1,342 or 4.4 percent higher than the level of $1,286 for the entire Province, compared with $852 or 3.4 percent above the Provincial average of $824 in 1983/84.

Operating Expenditures per Capita with Inflation ($)



Sources: Ministry of Health
Ministry of Treasury & Economics

Comparison of Operating Expenditure Allocations by Major Category



Source: Ministry of Health

According to Provincial Government spending policy, annual increases in total funding for health services in Southwestern Ontario over the next ten years will be lower than in the past. Without stronger controls over spending on health care and more effective and efficient provision of health services, the health system will deteriorate. The health status of people in the Region could suffer as a result.

Trends in Regional Spending

Consistent with trends in health care spending across the Province, current spending on health care by major category of expenditure has changed significantly over the past several years. Between 1983/84 and 1988/89, a significant proportion of health care spending shifted from institutions to physician payments, the Ontario Drug Benefit Plan and home care assistance programs. This shift in spending reflects more rapid growth rates in major areas of expenditure for physician payments and for drug benefits than for other major expenditures, as well as the implementation of Provincial Government policies aimed at curtailing hospital expenditures and developing community services.

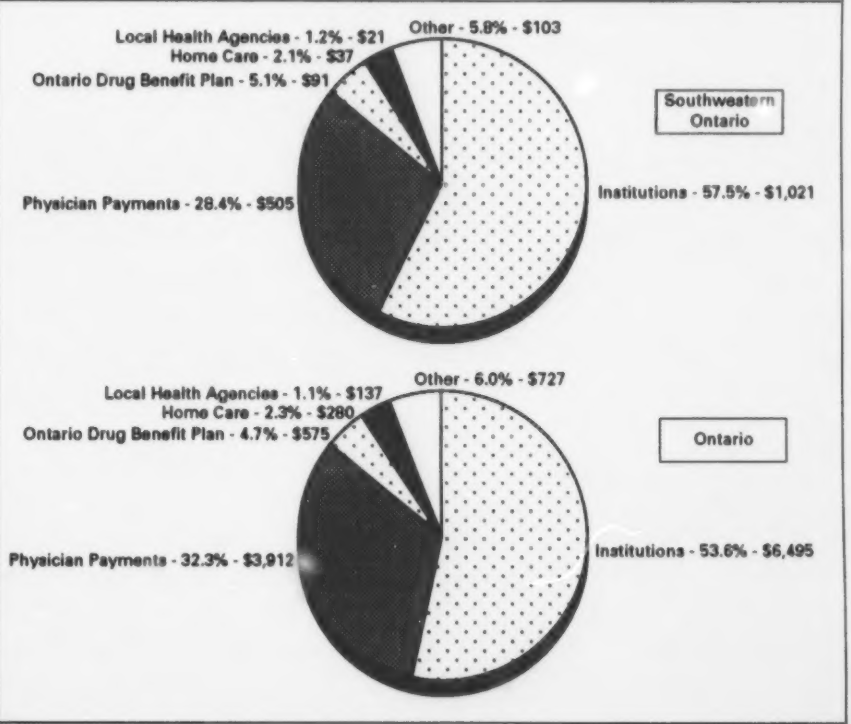
Current Spending

Institutional Services

The most significant difference in health care spending between the Southwestern Region and the entire Province is related to institutional services. Despite decreases in the proportion of health care spending on institutions in the Region over the past several years, more of the health care dollar continues to be spent on institutional services in Southwestern Ontario than in the Province as a whole.

As demonstrated by 1988/89 total operating expenditure data, health expenditures on institutional services in the Region were more than one billion dollars. This figure represented 57.5 percent of total spending in Southwestern Ontario, compared with six and one-half billion dollars or 53.6 percent for the entire Province of Ontario. On a per capita basis, institutional spending in Southwestern

Comparison of Total 1988/89 Operating Expenditure
($ Millions)



Source: Ministry of Health

Ontario in 1988/89 was $770 compared to $689 in Ontario as a whole, or 11.8 percent higher than the entire Province.

There are two major components of the difference in institutional spending between the Region and the Province. First, spending on teaching hospitals in Southwestern Ontario (the Health Sciences Complex) was 19.6 percent of total operating expenditures in the Region while teaching hospital spending across the Province was 17.5 percent of total Provincial operating expenditures on health care. Of lesser impact on total expenditures, is the fact that a total of 4.3 percent was spent on nursing homes versus 3.3 percent in Ontario.

The higher costs of institutional services in Southwestern Ontario are the major reason for the higher costs of total health care costs per capita in Southwestern Ontario compared with the Province as a whole.

Physician Services

In 1988/89, total operating expenditures on physician services in Southwestern Ontario represented 28.4 percent of all health care expenditures, which was well below the provincial norm of 32.3 percent. Furthermore, between 1983/84 and 1988/89, physician costs increased at an average annual growth rate of 11.7 percent compared with an average rate of growth of 12.9 percent for the entire Province.

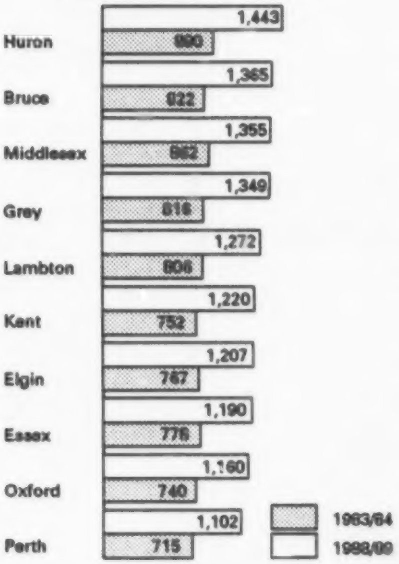
Despite the relatively lower costs and growth rate in comparison with the Ontario norm, the high percentage of total costs devoted to physician services and the high rate of growth in these costs over the past several years is a cause for major concern within the health system in the Region.

Spending Patterns Within the Region

Over time, there has been a significant shift in the distribution of health system resources on a county basis. Based on referral populations (total population served by the health care system within a particular geographic area regardless of where these people live), the range in total operating expenditures per capita by county between the highest and lowest expenditure was 30.9 percent in 1988/89 compared with 24.5 percent in 1983/84. This shift has occurred as a result of many different events rather than through any planned or conscious effort to meet the needs of the populations served in the individual counties.

There are major health issues and priorities which need to be addressed in each area throughout the Region. The health system must be planned and managed and resources allocated more effectively than in the past to meet these needs.

Comparison of Total Operating Expenditures per Capita Referral Population with Inflation



Source: Ministry of Health

From Institutional to Home-based Services

Health institutions, including hospitals, nursing homes and homes for-the-aged, play an essential role in the health care system. Central to this role is the provision of services to patients and residents who stay in these facilities for all or part of the time when they are receiving care. In some situations, with sufficient ambulatory care, community-based and in-home programs in place, it is possible, and preferable from the individual's perspective, to provide the same services in people's homes.

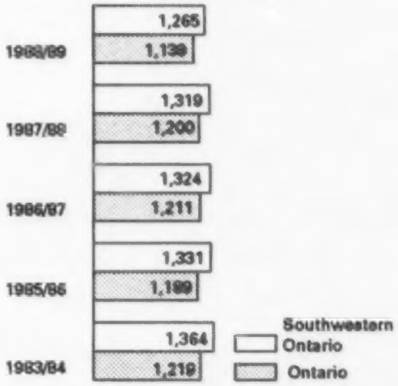
For the past several years, Ontario Ministry of Health policy has supported the replacement of institutional-based health services with community services. The results of this effort are reflected in declining rates of institutionalization across the Province, including Southwestern Ontario.

Despite the trend to lower rates of institutionalization, the Region has maintained a higher use of inpatient services in comparison with the rest of the Province. For example, in 1988/89, the total number of acute care patient-days of in-hospital service per capita was 11 percent higher in the Region than for the entire Province. Within the Southwest Region, Middlesex is the only county with a lower number of acute care patient-days per capita than the provincial average.

Also, in 1989, there were a total of 165 long-term care beds per 1,000 people of age 75 years or over in hospitals, nursing homes, and homes for-the-aged, compared with an average of 155 beds across Ontario.

Hospital beds, once a focal point for planning the health care system, are no longer the only measure of the quality and accessibility of health services. As recognized by the Premier's Council on Health, many services which were once provided on an in-patient basis, can now be delivered by other, more effective means while the person remains in his or her own environment. There is a significant opportunity to improve the utilization and effectiveness of the health

Number of Acute Care Patient Days per 1000 Population



Source: Ministry of Health

care system in Southwestern Ontario and to free up money for other purposes by the increased delivery of services through out-patient ambulatory care centres and to people in their homes.

The development of increased community-based and home support services will be critical to meeting the health care needs of the people of Southwestern Ontario. Enhanced community services will be of particular importance in the delivery of long-term care.

Needs-Based Health Services

As described previously, little information exists on health status and considerable research is needed on how to measure and assess health needs. Notwithstanding these limitations, it is clear from the public consultation process that not all residents of the Region have equal access to health services, particularly those people living in remote areas where the limited demand for services makes it difficult to attract health professionals and to cost justify the establishment of permanent health services.

Also, as previously noted, the population of the Region is not homogeneous in terms of its needs for health care. There are many groups of people within Southwestern Ontario who, by virtue of their geographic location, type of employment, ethnic background, or predisposition to particular diseases, have special health care needs. Aboriginal Peoples, the elderly population, people in the Bruce Peninsula, the farming community in Huron and Perth Counties and the Low German-speaking population in Elgin County are examples of such groups.

The determinants of health and the health needs of any person or particular group of people span a broad spectrum of services within and beyond the health care system. For example, meeting identified health needs might involve providing better education with respect to disease prevention, increased access to physician services, more frequent diagnosis and testing services, better in-home support, alternate forms of accommodation and more intensive in-hospital treatment. In addition, changes to environmental, social, and economic policies or programs which are beyond the control of the health care system may also be required in order to obtain the desired health outcome. Coordinating mechanisms will be needed to address these kinds of programs.

The planning and prioritizing of health services must become more focused on the entire health needs within the community, rather than the existing, somewhat fragmented approach to service planning which focuses on past trends in the utilization of health care services. In order to achieve this objective, better empirical information and more input from the public on health needs is required. Within a new context of needs-based planning, there will be major opportunities for service providers to take on new and expanded roles and to provide more innovative and cost effective ways of delivering services which meet the entire health needs of particular communities.

In the development of needs-based health services it must be recognized that potentially, there is no limit to the level or amount of care which can be provided, particularly with respect to community services. The planning process will need to deal with the complex ethical and moral issues which surround the provision of health care. The public, through health care planners, decision-makers, and care providers, must come to grips with such issues as: How much care is enough? For how long should care be provided? In what circumstances should care not be provided? What are an individual's rights when it comes to receiving or discontinuing treatment? These and other moral and ethical issues are profoundly related to the quality of life of the individual, the professional ethics of care providers, and the overall costs of the health care system.

Hospital Services

Hospitals represent the single, most expensive component of the health care system in Southwestern Ontario. In 1988/89, hospitals accounted for almost 50 percent of the total health care operating expenditures; the three London teaching hospitals alone accounted for approximately 20 percent.

The role of the Health Sciences Complex includes the provision of primary, secondary, and tertiary care for the local community as well being the major referral centre for secondary, tertiary and quaternary care and the only centre for medical education and research in the Region. The Health Sciences Complex serves patients from all areas throughout the Region. In fact, according to 1991 Ministry of Health data, the 1991 referral population for areas served by these hospitals is estimated to be 45 percent higher than the number of residents who actually live in the County of Middlesex.

This high referral population suggests that, in addition to tertiary services, a significant amount of secondary hospital care is being provided by the Health Sciences Complex to people who live in some areas outside of the London area. These people often travel long distances to receive health services, some of which could be provided closer to home if increased capacity for secondary services were developed in the local areas.

The future role of the Health Sciences Complex should be redefined to promote the development of increased capabilities in community hospitals throughout the Region. At the same time, its recognized contribution to the provision of tertiary and quaternary care, health education and research both within Southwestern Ontario and at a provincial and national level, must be preserved.

Coincident with a redefined role for the Health Sciences Complex, the capabilities of community hospitals throughout the Region will need to be enhanced to include the increased capability to provide secondary care services.

In addition to these changes, implementation of the Provincial Government's initiative to redirect the delivery of long term care in the Province away from institutional services will also change the existing role of hospitals.

Coordination of Capital Planning

Currently, health service providers are responsible for the long-term planning and development of their facilities. The capital spending initiatives of service providers have significant impacts on the nature, quality and accessibility of services and on the overall effectiveness and efficiency of the delivery of health care. During the period when most hospitals in Southwestern Ontario were established, individual service providers made their own capital development decisions, subject to the needs of their catchment area populations as the providers identified them and to funding approval by the Ministry of Health.

Over the years, this approach to planning has led to the duplication of hospital services and facilities in many communities across the Province. The Southwestern Ontario Region has not been an exception to this process. Several cities in the Region have more than one community hospital; the City of London has three teaching hospitals offering a range of similar services. In some cases, there are opportunities to rationalize these services, thereby improving cost effectiveness.

One of the reasons for the establishment of District Health Councils was to coordinate the capital development needs of service providers in local areas throughout the Province. The responsibilities of the District Health Councils include the ability to prioritize the capital requests from service providers within their respective areas, encourage local providers to undertake cooperative planning efforts and make recommendations for funding approval to the Ministry of Health.

District Health Councils have played an important role in bringing local service providers together to plan and implement facilities development projects on a more cooperative basis. These projects, in turn, have contributed to the elimination of service duplication in some areas and the establishment of joint service programs between institutions and community-based health service agencies. However, District Health Councils do not have any direct responsibility for the approval or administration of capital funds and instead, hospitals often rely on political persuasion to gain financial support for their facilities development projects. The lack of financial responsibility has been a significant factor in limiting the ability of District Health Councils to improve the accessibility, effectiveness and efficiency of health services through the rationalization of health facilities and planning efforts.

Although some rationalization of services has been made, progress is slow and service providers are continuing to present capital development plans which focus to a large degree on needs as they alone define them, instead of the needs of the health system as a whole. Present approaches to managing capital investments in the health system need to be changed in order to permit a more proactive, system-wide approach to improving the cost effectiveness of health services and to replacing outdated facilities.

Return On Capital Investment

Historically, capital investment decisions have been made on the basis of service and facility redevelopment needs, with limited consideration to the potential return on investment from improved productivity and reduced operating costs. Service providers have not been held accountable for the economic impacts of their capital investment decisions. The depreciation of buildings, building equipment, and other facilities has not been an allowable operating expense. Without any direct link between capital and operating expenditures, there is no financial incentive for service providers to improve the on-going efficiency of their operations or the health system through capital investments which result in the rationalization of services or the development of alternate methods of service delivery.

THE PLAN:
TOWARDS BETTER MANAGEMENT OF OUR HEALTH

THE PLAN: TOWARDS BETTER MANAGEMENT OF OUR HEALTH

Summary

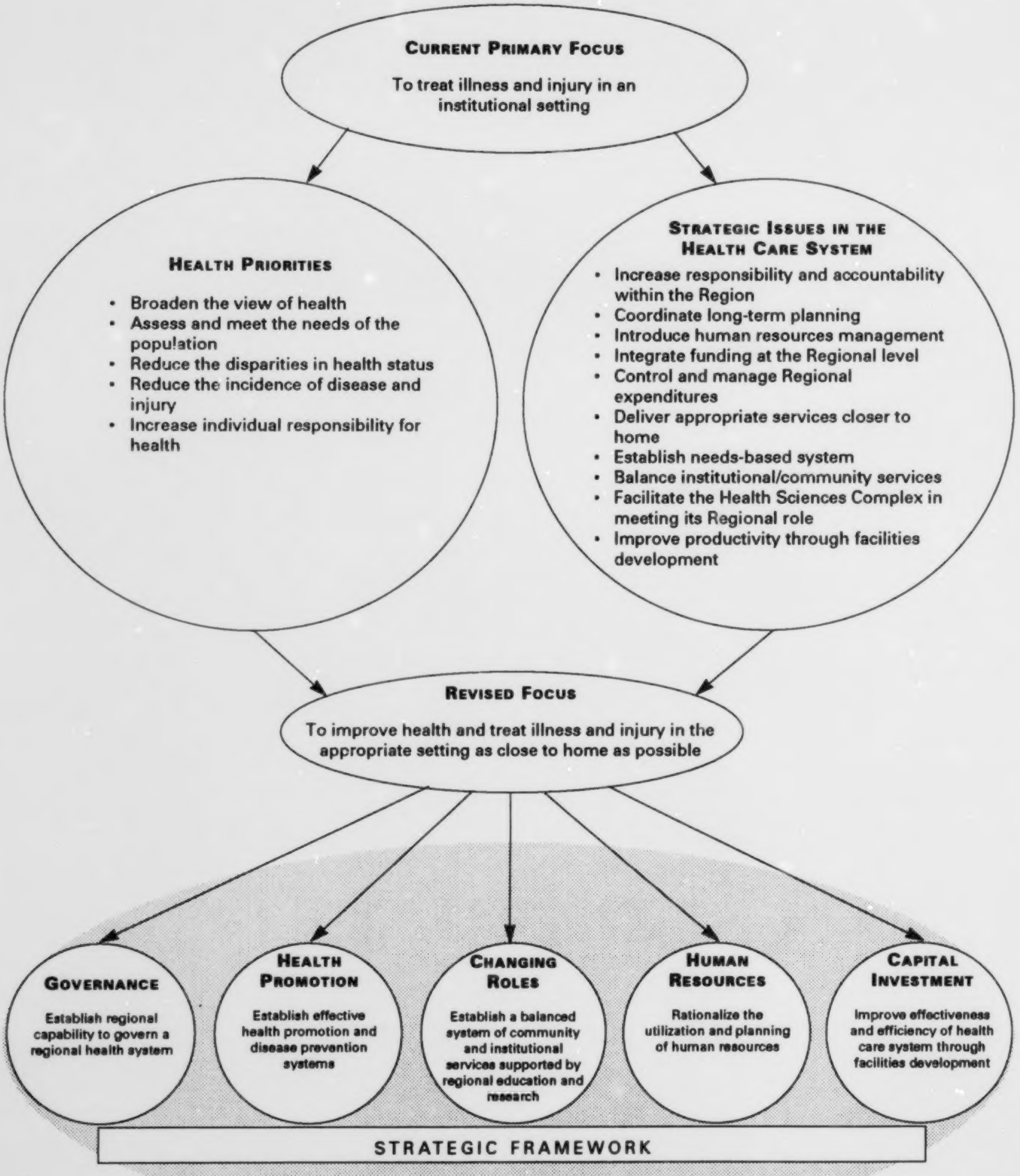
The health needs and priorities of the people of Southwestern Ontario today can best be met through the establishment of a regional health care system which focuses on both the improvement of health and the treatment of illness and injury in the most appropriate setting as close to home and as cost effectively as possible.

The plan for improving health for all in Southwestern Ontario is based on a strategic framework which reflects five underlying strategies. Together, these strategies have been designed to create a health care system which is governed and managed at the Regional level. These strategies are:

- devolution of Provincial Government responsibility and resources into a regional structure of governance for the total health care system in Southwestern Ontario;
- investment of increased resources in health promotion and disease prevention;
- provision of more health care closer to home through the enhancement of services in the community and the enhanced capability of community hospitals;
- establishment of an integrated approach to planning, managing, and educating the human resources which are required to meet the health care needs of the Region, and
- implementation of a capital investment strategy which is designed to achieve necessary improvements in health facilities and contribute to increased overall efficiency and effectiveness of the health care system.

Ten-year targets for the reallocation of operational funding among major categories of health expenditure have been established to serve as guidelines for the implementation of the plan.

A STRATEGIC PLAN FOR IMPROVING HEALTH IN SOUTHWESTERN ONTARIO TO THE YEAR 2001



CURRENT PRIMARY FOCUS

To treat illness and injury in an institutional setting

HEALTH PRIORITIES

- Broaden the view of health
- Assess and meet the needs of the population
- Reduce the disparities in health status
- Reduce the incidence of disease and injury
- Increase individual responsibility for health

STRATEGIC ISSUES IN THE HEALTH CARE SYSTEM

- Increase responsibility and accountability within the Region
- Coordinate long-term planning
- Introduce human resources management
- Integrate funding at the Regional level
- Control and manage Regional expenditures
- Deliver appropriate services closer to home
- Establish needs-based system
- Balance institutional/community services
- Facilitate the Health Sciences Complex in meeting its Regional role
- Improve productivity through facilities development

REVISED FOCUS

To improve health and treat illness and injury in the appropriate setting as close to home as possible

GOVERNANCE

Establish regional capability to govern a regional health system

HEALTH PROMOTION

Establish effective health promotion and disease prevention systems

CHANGING ROLES

Establish a balanced system of community and institutional services supported by regional education and research

HUMAN RESOURCES

Rationalize the utilization and planning of human resources

CAPITAL INVESTMENT

Improve effectiveness and efficiency of health care system through facilities development

STRATEGIC FRAMEWORK

Overview

In the past, like most jurisdictions, the primary focus of the delivery of health care in Southwestern Ontario has been on the treatment of illness and injury predominantly in institutional settings. Most health care services have been aimed at treating or curing specific health problems of individuals on an episodic basis. It is within such an environment that the existing health care system in the Region has been established.

Over the next ten years, several priorities must be addressed in order to improve health for all. The perceptions held by the public and service providers need to be broadened to include, as central notions, the social, economic and environmental determinants of health and the importance of maintaining good health in order to help prevent injury and disease. Impacts of population growth and aging on the health needs of the Region must be addressed. Disparities in health status which arise from social, economic and cultural disadvantages among particular groups need to be reduced or eliminated, as does the incidence of disease and injury with respect to health problems which are more prevalent in Southwestern Ontario than in the rest of the Province. The role and the responsibility of the public in addressing these priorities and in making appropriate use of the health care system also need to be enhanced.

Coincident with the priorities for improved health, the effectiveness and efficiency of health care delivery in the Region need to be improved. Increased responsibility and accountability within the Region is required. Long-term planning, human resources management and funding processes need to be integrated and better controlled. Shifts in the delivery of health care are required to deliver appropriate services closer to home. The central role of the Health Sciences Complex in patient services, education and research throughout and beyond the Region needs to be supported. Major development of health facilities is required in order to support the shift in emphasis in the delivery of care, improve the efficiency of the system, and replace obsolete facilities.

Addressing both the priorities for improving health and the strategic issues in the health care system will be major challenges for the delivery of health care in Southwestern Ontario to the year 2001.

It is clear from the public consultation process and input from service providers, that people are becoming aware of the potential benefits of a holistic approach to health and the rational and systematic delivery of health care services. Future efforts at improving the provision of health care in Southwestern Ontario must enhance and support the new concepts of health and health care delivery which are already taking place, while initiating further, more innovative and extensive improvements.

Strategic Framework

The plan for improving health for all in Southwestern Ontario is based on a strategic framework which includes five underlying strategies. These strategies have been designed to create a genuine health care system which is governed and managed at the Regional level.

> *"We heartily endorse the five key strategies underlying the Plan to better manage our health and our health system."*
>
> St. Mary's Memorial Hospital
> Commission Public Consultation Process
> September to October 1991

Governance

The capability of people in the Region to govern their own health care system will be enhanced. The responsibility and accountability for planning, funding allocations, operations management and capital development will be integrated at the Regional level coincident with the devolution of Provincial Government responsibilities and authority.

Health Promotion and Disease Prevention

Increased emphasis will be placed on health promotion and disease prevention through enhanced programs which, in addition to addressing high priority health issues, take into consideration social, economic and environmental factors which influence health. Additional financial resources will be provided for these efforts through the reallocation of funds which are currently being spent in the Region on other aspects of health care.

Service Delivery

Building on the vision, goals and objectives established by the Premier's Council on Health Strategy, the delivery of health services in Southwestern Ontario will be enhanced in order to meet health needs as effectively and efficiently as possible in the most appropriate setting. Services will be planned and provided according to the following objectives:

- meeting the total health needs of the individual within the context of the broad determinants of health;
- providing a balanced approach to the maintenance of good health as well as the treatment and cure of illness;
- increasing the involvement of people in managing their own lifestyle in support of good health;
- empowerment of individuals to play a stronger role in identifying and addressing the health needs within their communities;
- coordinated planning, development, and delivery of health services to meet health needs in the most efficient and effective manner possible;
- coordination of health and social services where appropriate;
- the provision of more health services in community-based settings or in the home where feasible, and
- enhancement of the role of the Health Sciences Complex in the provision of tertiary care, education and research.

In the short-term, the primary focus will be on improving services which are budgeted for, and provided directly by, the health care system. However, over the next ten years, increased attention will be paid to addressing social, economic, and environmental factors.

> *"A health strategy for the 1990s which will best serve this community will be one where the health of an individual is seen not primarily as something to be restored when illness strikes. A progressive and dynamic health strategy will see the health of an individual as something that can be maintained and promoted through such things as proper nutrition, healthy environments (including good housing), healthy lifestyles, judicious medical care, and easy access to support services when the stresses and pressures of life build up."*
>
> Low German-Speaking Community of Elgin County
> Commission Public Consultation Process
> October to November 1990

Human Resources

Planning and management of human resources will become more integrated at the Regional level and will be geared to meeting the health needs of individual communities. The substitution of one type of health professional for another, service reorganization, changes to educational programs, and financial incentives will be employed to meet human resource demands, particularly those in underserviced areas. The management of physician services will include measures to control the number, location and types of physicians based on need, alternate funding arrangements to support new approaches to service delivery and reduce the growth in the total costs of physician services, and mechanisms to monitor service utilization.

Capital Investment

The development of health facilities will be based on an integrated, ten-year capital spending strategy which is designed to achieve the necessary improvements in health facilities and improve the efficiency and effectiveness of the health care system. Capital projects will be required to generate a rate of return in reduced operating costs which is at least sufficient to offset the cost of capital.

Spending Allocation Targets

Based on the financial restraint policies of the Provincial Government, it is unlikely that there will be additional new operating funding to implement the initiatives contained in the plan. Therefore, coincident with the implementation of the plan, the total costs of health care will need to be contained within the overall levels of funding allocated to the Region from the Provincial Government.

> *Very few people, if any, will deny that we must take some bold steps if we wish to bring health care costs under control and bring them under control we must!"*
>
> Sarnia Hospital Centre
> Commission Public Consultation Process
> September to October 1991

Ten-year targets for the reallocation of operational funding among major categories of health expenditure in the Region have been established to serve as guidelines for the implementation of the plan and control future health care spending.

THE PLAN: TOWARDS BETTER MANAGEMENT OF OUR HEALTH

Summary

Today's environment calls for a much more rigorous approach to managing health services and health care costs than has been used in the past. Continued economic constraints will require difficult trade-offs to be made between competing health needs and priorities, as well as significant rationalization of existing services at the regional and community levels within Southwestern Ontario.

At present, there are no well-understood, Province-wide strategies for advancing health in the 1990s, nor are there any comprehensive planning guidelines for regions, areas, communities, and service providers to identify and meet their health needs. It is probably impossible to plan and manage effectively the health system for 10 million people on a centralized basis. It will, therefore, be necessary to divide the Province into several regions, such as Southwestern Ontario, which, by virtue of their population size, health needs, and patterns of health care activity, can be managed on a self-sufficient basis.

The existing centralized approach to governance and management of the health care system of Southwestern Ontario will be replaced with a regional system through a devolution of responsibilities and resources from the Provincial Government.

A Southwestern Ontario Health Management Board will be established and held accountable jointly to the Government of Ontario through the Minister of Health and to the people within the Region for overall management of the health care system. This Board will be responsible for long-term planning, allocating operating funds to six Area Health Management Boards and a Regional Health Sciences Management Board, approving capital expenditures, managing human resources and supporting the coordination of education for health professionals. The Area Health Management Boards will be directly responsible for overseeing the health system within geographic areas which comprise the Region. The Regional Health Sciences Management Board will oversee the system for providing tertiary care services.

THE PLAN: TOWARDS BETTER MANAGEMENT OF OUR HEALTH

Summary

The new governance structure will support and enhance the roles of service providers, including the important role of the Health Sciences Complex in academic medicine, research, and tertiary care at a regional, provincial, and national level. The new boards will work with service providers and representatives of the public in identifying and meeting the health needs of the Region. The Ministry of Health will retain its existing responsibility for establishing overall policies, standards and guidelines for the health care system across the Province.

The new Regional and Area Health Management Boards will be governed by appointed boards of directors which include representatives from the public, local government and service providers. The new structure will be created through a transfer of responsibilities and resources from both the Provincial Government and the five District Health Councils in the Region. In this way, there will be no additional bureaucracy or significant additional costs for the management of the system.

The Southwestern Region will be allocated a total funding envelope from the Provincial Government for managing and operating its health system. This envelope will include operating and capital funding for institutions and community agencies, OHIP payments, drug benefits, public health programs, and other direct health care expenditures. The Regional and Area Boards, together with service providers will be held accountable for meeting the health needs of Southwestern Ontario within this funding envelope.

The Southwestern Ontario Health Management Board will have authority and responsibility for funding all elements of the health care system which are utilized for education and research. However, the Government of Ontario will retain responsibility for funding health education and research programs of the Health Sciences Complex, other service providers, and educational institutions in the Region. The municipal portion of mandatory health program funding will be funded by the Province as part of the funding envelope for Southwestern Ontario.

Limitations of the Existing System

Introduction

Traditionally, the provision of health care in Southwestern Ontario has been governed through an approach in which major service planning and funding decisions are made centrally by the Provincial Government. When financial resources are limited, these decisions involve making tradeoffs and compromises between competing community needs for service. At the same time, there are needs and opportunities within the Region to improve the delivery of health care through more effective coordination of services at the community level, reallocation of funding, needs-based planning, better human resources management, and more meaningful management information. The ability of the existing system to make the fundamental changes necessary to ensure that appropriate health services are provided throughout the Region on a cost-effective basis can be improved.

Service Planning and Coordination

A wide range of advisory and coordinating bodies exist whose primary role is to provide coordination within various segments of health care and related social services. The bodies have included:

- Premier's Council on Health Strategy;
- Ministry of Health/Ontario Medical Association Task Force on the Use and Provision of Medical Services;
- individual District Health Councils;
- Community Health and Support Services Division, Ministry of Health and Ministry of Community and Social Services;
- DHCs of Southwestern Ontario;
- London Teaching Hospitals Council;
- Placement Coordination Services;
- Seniors advisory councils and other community associations;
- Home Care Programs, and
- Public Health Units.

Limitations of the Existing System

However, coordination of health care is lacking. Fragmentation of programs and services exists, not only in Southwestern Ontario, but also across the Province. The Provincial Government, Local Government, communities and service providers are all key players in this process.

Provincial Government

By virtue of their size, complexity and role in supporting the political process, provincial ministries are, by nature, bureaucratic and slow to make decisions. In addition, differences in organizational philosophies between the Ministry of Health and the Ministry of Community and Social Services are also limiting the ability to coordinate services. The Ministry of Health is centralized and services are organized on an institutional basis, while the Ministry of Community and Social services is decentralized and organizes services on a program basis. Within the Ministry of Community and Social Services, most of the decision-making regarding funding allocations, major programs and agencies takes place in regional and area offices. Within the Ministry of Health, such decisions take place centrally. These differences create difficulties in communication and coordination of joint efforts between the two ministries. The Community Health and Support Services Division, with joint responsibility to the Ministry of Health and the Ministry of Community and Social Services, will help to overcome these difficulties with respect to long-term care.

Local Government

Municipal governments currently fund 25 percent of mandatory public health programs, while the Province is responsible for funding the remaining 75 percent. Operationally, this division in funding responsibility has contributed to some fragmentation in the delivery of public health programs.

Limitations of the Existing System

Communities

In the current health care system, with major decisions on health programs and funding being made centrally, there is insufficient capability to understand local and regional needs and adapt services to meet these needs.

Local service providers believe that the approval process for funding health programs is complex and lengthy. In some cases, a service provider must go through four levels of bureaucracy to obtain final approval.

From the public perspective, the existing approach to planning and delivering health services focuses more on the particular roles and service capabilities of the service providers, rather than on the total health needs of the community. As a result, some programs and services are duplicated between providers, while other more important health priorities may not be adequately addressed.

In recognition of this problem, some service providers have initiated coordinated planning efforts involving institutional and community-based agencies within their planning areas. There is the need to go further with such efforts and, in particular, to create mechanisms which ensure that individuals within local communities play a stronger role in identifying the health needs and in establishing health priorities and services within their local areas.

Service Providers

Currently, health care institutions are accountable primarily to their individual boards of trustees, for providing health care in their defined catchment areas. They report directly to the Ministry of Health in terms of funding allocations and accountability. Decision-making occurs largely on an institution by institution basis and focuses on the particular role of the institution rather than the continuum of health needs of the public. There is the need for more collaborative and coordinated planning among service providers.

Limitations of the Existing System

There is evidence that coordination of planning and service delivery among health care institutions is beginning to occur. The London Teaching Hospitals Council was recently created to develop information-sharing and coordinated strategic planning among University Hospital, Victoria Hospital, and St. Joseph's Health Centre which, together with the University of Western Ontario, constitute the Health Sciences Complex. The four community hospitals in Windsor have initiated a planning process to rationalize and consolidate services. However, a lack of clear and agreed-upon planning guidelines and planning capabilities among many organizations, including hospitals and other institutions, is limiting their ability to plan and operate effectively.

Many organizations are also frustrated with the lack of control over implementation of their plans. District Health Councils may develop plans and priorities, but they may be significantly revised by the Ministry of Health and approval of plans may be delayed for years due to administrative roadblocks beyond the Regional level.

Management of Funding

The current funding system is not based on an objective, critical assessment of need. As a consequence, existing inequities between institutions and programs are perpetuated and others created. The funding system limits the Provincial Government's ability to reallocate operating and capital funding based on changing needs; for example, from one area in the Region to another, from emphasis on curing to prevention, or from institutional-based to community-based care. In addition, there are limited incentives for cost containment in the system.

Operating Funds

At present, annual operating funds for the various components of the health care system are approved through "vertical" votes in the Provincial Legislature. For example, there are separate votes for:

- institutional health (primarily hospitals and related facilities);
- community and personal health programs including community health services such as home care, mental health, emergency services, and public health through transfers to municipal and local health agencies, and
- health benefits including insurance and drug benefits.

Once funding for these components has been approved by the Provincial Legislature, the funds are distributed throughout the Province. The majority of these funds (other than health insurance benefits, commonly known as OHIP) is distributed based on local requests. The current system is essentially an incremental system in which funds are distributed to individual service providers based on the previous year's budget plus an increase which allows for inflation, new programs and to a limited degree, for changes in the volume and intensity of services.

Health insurance benefits are distributed on the basis of an open-ended insurance fund, through which doctors bill the system on a fee-for-service basis. Until the recent agreement was reached between the Government of Ontario and the Ontario Medical Association, there were no constraints on the total costs for medical services. With the latest agreement, some modest constraints are intended.

The current funding system has permitted rapid escalation of health care costs. Not only is the cost of the system growing very rapidly, there are no assurances that funding is going to where it is most needed. There is no mechanism in Southwestern Ontario which can make the appropriate trade-offs in funding allocations among the major categories of spending which are governed by separate votes, for example,

Annual Growth Rate in Ontario Health Care Expenditures Between 1980/81 and 1990/91 (%)

	With Inflation	Without Inflation
Hospitals	11.0	4.5
OHIP	13.5	6.8
Ontario Drug Benefit Plan (ODBP)	19.1	12.1
Other Programs	11.6	5.0
Total Ministry of Health Budget	12.1	5.6

Source: Ministry of Health

between health promotion and hospitalization or operating and capital.

Capital Funds

Currently, capital investment decisions for facilities and major equipment are made on an individual facility basis. Each capital investment proposal is submitted by the proposing organization to the District Health Council for evaluation and approval and then to the Ministry of Health which analyzes the proposal and makes a recommendation for approval.

Notwithstanding the efforts of the District Health Councils which have had a significant impact on setting priorities and coordinating efforts on a local area basis, this system has generally resulted in capital investment decisions which:

- are not based on consideration of overall needs of the health care system;
- are, on occasion, based on the needs of particular interest groups which have circumvented the recommendations of the District Health Councils through the political process;
- are not made within a framework for decision-making which would enable priority setting by the Ministry of Health;
- do not factor the cost of capital into management decision-making. The cost of capital investment is not linked to financing, operating and maintaining buildings or equipment, and
- have contributed to the current emphasis on hospitalization and a high number of acute care beds in Southwestern Ontario.

Cost Containment

The current funding methods lack incentives for the public, health care professionals and institutions to use health care resources as effectively and efficiently as possible. People are unaware of the cost of service received. Since funding allocations are based on established formulas and fees for service, there is limited emphasis on measures of performance which would result in overall efficiencies in the health care system.

The drive for cost containment has created competition for funding and duplication of health services. This approach favours the large, well-organized institutions which are most likely to be successful. The financing of budget overruns has tended to flow back to the Province, rather than to the individual or organization which is in the best position to manage and be accountable for the costs of health service.

Health Education and Research Funds

At present, the funds available for the support of education and for the recompense of university and college teachers engaged in research are derived from a bewildering array of sources. Grants from the Ministries of Colleges and Universities, Health, and Community and Social Services; fees from students; payments from OHIP derived from the clinical services provided by clinical faculty members operating under 'ceiling' systems; support from teaching hospitals and foundations; and grants-in-aid from government and private research agencies, are combined in an unstable and uncoordinated fashion to support an activity that is essential to the continued operation of health services, in Southwestern Ontario and elsewhere in Canada. There is essentially no overall control of this array of funding sources; nor is there assurance of the continuance of any individual source for more than a relatively short time. Therefore, effective planning for the future of education and research is not really possible under existing circumstances.

An initiative presently underway to attempt to rectify the more acute of these problems is the development of an alternative funding plan by the Faculty of Medicine of the University of Western Ontario. The objective of such a plan is to provide the Faculty with a global budget to finance its combined responsibilities for education, research, and the provision of associated clinical services. Such services, of course, are highly significant to the Region, given that a very large proportion of the tertiary and quaternary services (and a significant proportion of the secondary services) provided by the institutions of the Health Sciences Complex are delivered by physicians and surgeons who are members of the Faculty of Medicine.

The development of an alternative funding plan would facilitate greatly the preparation and implementation of sensible plans, not only for the education of students and the conduct of research, but also for the provision of an appropriate range of clinical services by the institutions of the Health Sciences Complex.

Human Resources Management

Medical professionals are accountable to their professional bodies in terms of medical standards and to the health care institutions in which they practice. However, regional responsibility for ensuring the consistency and availability of medical services delivered by professionals, relative to need, currently does not exist. This has contributed to uneveness in the distribution of services throughout the Region.

Little forecasting and coordination of human resource planning and deployment has existed, leading to inappropriate and insufficient staffing of some institutions and other health organizations.

Some primary, secondary and long-term care services could be provided by a wider range of professionals. The substitution of one type of health professional for another represents an opportunity to contain costs and support the treatment of individuals near, or in their own residences. However, there is no mechanism in place to ensure that the full benefits of substitution can be achieved.

Management Information

There is a lack of meaningful information to support effective management decisions with respect to the health care system in Southwestern Ontario.

Limitations of the Existing System

Until recently, there was little focus on measures which would allow decisions to be made with consideration given to the cost-effectiveness of health care. For example, information with respect to individual levels of health, cost per type of service, the cost and benefits of spending on prevention programs and the impacts of new technology and other investments has been lacking in the system.

There is no complete database of information on the health of individuals. The potential redesign of the OHIP database for Regional purposes and the development of "health intelligence units" by Health Sciences Complexes to collect and analyze information on health status and needs, are two initiatives which will help to build the necessary information base. However, at present, neither individuals nor service providers have complete knowledge of the cost of treatments, the type and level of service delivered or the outcome produced, relative to an individual's health or the health of the population.

Key Objectives for Improvement

Based on the foregoing concerns with the existing system of governance and management, the following objectives for improvement will be adopted:

- **Planning** will be improved at all levels - local, regional, provincial. Planning will include projections of needs, methods of service delivery, and resources required (particularly human resources).
- The **coordination** and rationalization of services among service providers, such as physicians, hospitals, long-term care providers, and community services will be increased. A team approach to service delivery will be fostered.
- The **responsiveness** of the system to community and individual needs will be enhanced.
- The **accountability** for decisions with respect to the level and cost-effectiveness of services and the level and method of funding allocations will be increased at the Regional level.
- The accountability for the **management of outcomes** which identify the results of health care interventions by providers in terms of the quality of individuals' health will also be increased. A logical decision-making process for management of the health care system will be established.
- The **quality, relevance and accessibility of information** needed to manage the health care system and the health of individuals will be improved.

The health care systems in many other jurisdictions, such as British Columbia, Quebec, Manitoba, New Zealand, Sweden, and the United Kingdom are under review. Many jurisdictions are considering devolution or further devolution of responsibility as a means of achieving necessary improvements.

A Regional Governance Structure

The Imperative for Change

At present, there are no well-understood, Province-wide strategies for advancing health in the 1990s, nor are there any comprehensive planning guidelines for regions, areas, communities, and service providers to develop and manage the health care system. The large population of the Province, together with the diversity of character and needs of its many regions, areas, and communities, represents an overwhelming challenge in meeting health needs. It is probably impossible to plan and manage effectively on a centralized basis, the many diverse elements of the health system to meet the health requirements of more than 10 million people.

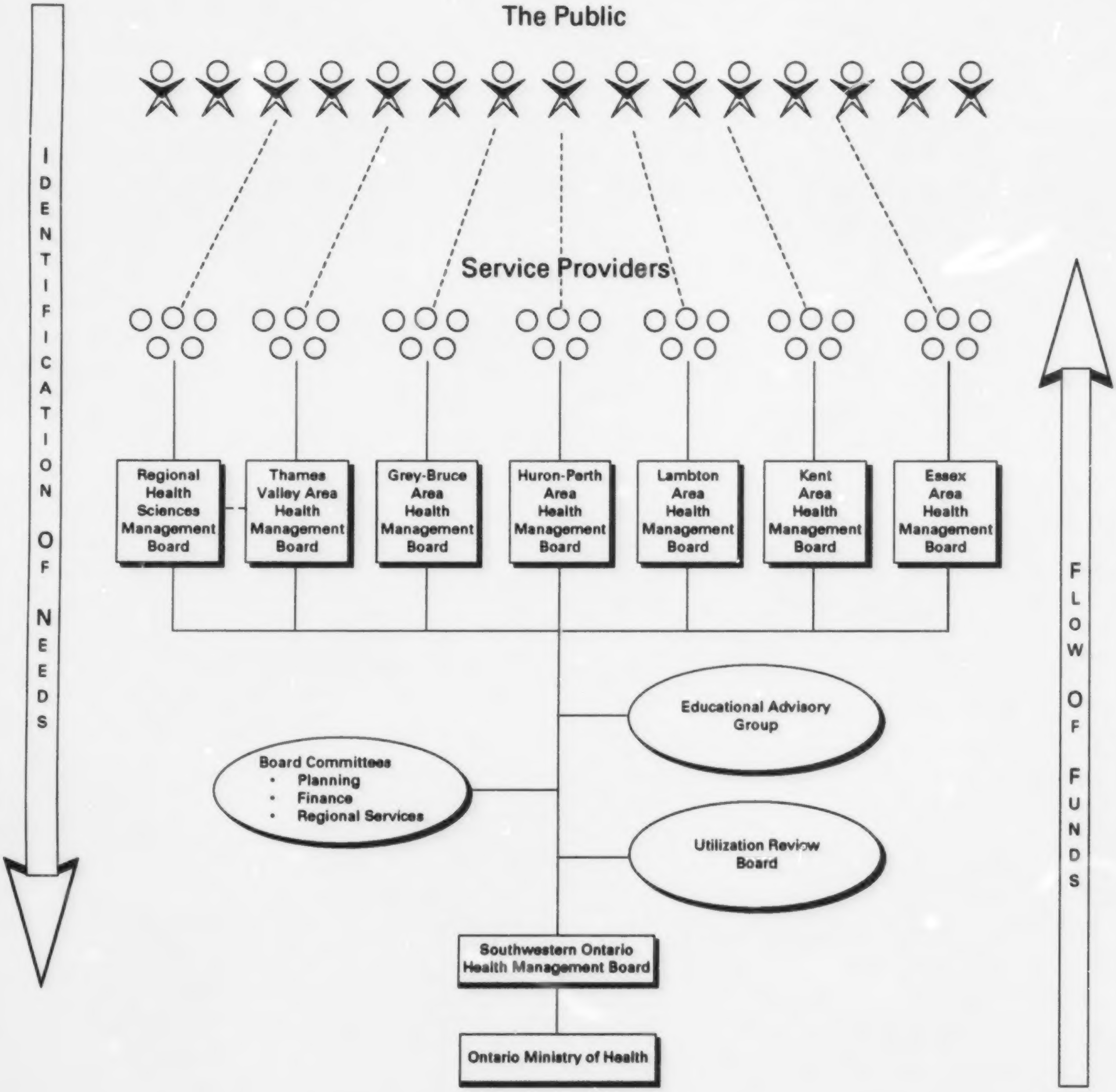
It will, therefore, be necessary to divide the Province into a number of regions whose population size, health needs, and patterns of health care activity make them logical subdivisions of the whole Province. Southwestern Ontario represents one such logical subdivision for planning and management. The Region is "self-sufficient" insofar as substantially all of the health needs of residents are met from within its borders and the special needs of the people in Southwestern Ontario can be identified and addressed.

In the future, it will also be imperative that the health system is managed in such a manner as to provide the best possible level of health and health care within the limits of available funding. A framework of governance and management, suitably sized and organized to achieve the necessary improvements is essential to achieve this objective.

In addition, the health system will need to be governed by processes which permit difficult trade-offs between different, and arguably equally important, needs and priorities. Planning decisions will become increasingly needs-based and more closely related to health outcomes. At the same time, existing services must be rationalized in order to improve the efficiency of the system and thereby produce funds for new initiatives. Service providers must modify their traditional roles and plan and manage their operations on a more collaborative basis. If serious financial problems and a future

> *"In the absence of definitive policies, hospitals are doing the best they can, but most of them end up working in isolation."*
>
> Source: Dennis Timbrell,
> President,
> Ontario Hospital Association

A SOUTHWESTERN ONTARIO REGIONAL GOVERNANCE STRUCTURE SUPPORTING BETTER HEALTH FOR ALL


The Public
IDENTIFICATION OF NEEDS
Service Providers
Regional Health Sciences Management Board
Thames Valley Area Health Management Board
Grey-Bruce Area Health Management Board
Huron-Perth Area Health Management Board
Lambton Area Health Management Board
Kent Area Health Management Board
Essex Area Health Management Board
FLOW OF FUNDS
Educational Advisory Group
Board Committees
• Planning
• Finance
• Regional Services
Utilization Review Board
Southwestern Ontario Health Management Board
Ontario Ministry of Health

deterioration in services are to be avoided, change must take place at a faster rate and more extensively than efforts to rationalize have done in the past. It will be necessary to establish detailed plans for the major initiatives required to improve the health system. A new approach to governing the health care system in the Region is essential if these plans are to be achieved.

The Devolution of Responsibility

A regional governance structure which can efficiently organize and manage the job of meeting Southwestern Ontario's health needs in the 1990s, will be necessary to implement this plan. The fundamental concept behind this new structure will be the empowerment of people and organizations within the Region to make their own trade-offs and decisions with respect to health care within a total amount of funding allocated from the Provincial Government for this purpose. This will require devolution of much of the responsibility for governing the health care system from the Government of Ontario as identified by the Premier's Council on Health Strategy.

Accompanying the devolution in responsibility will be a major shift in decision-making accountability with respect to planning, delivery, and management of the costs of health care in Southwestern Ontario. Decisions concerning such matters as reallocating funds for new programs, rationalization of service providers, capital investments and how to deal with operating deficits will be made at the area or regional level instead of at Queen's Park. In turn, the Region will be held accountable for maintaining national and provincial health care standards and guidelines and for managing the system within the total of the funds allocated by the Provincial Government.

A New Regional Structure

The governing structure for Southwestern Ontario will include a health management board with responsibility for overall management of the health care system in the Region, six management boards responsible for the system of services within specific geographic areas in the Region, and a regional health sciences management board to

"The concept of regional and area management boards is, in our opinion, workable and sound."

St. Thomas-Elgin General Hospital
Commission Public Consultation Process
September to October 1991

oversee the system for providing tertiary care services. This structure will be created through a transfer of responsibilities and resources from both the Provincial Government and the five District Health Councils within the Region.

These new boards will be independent of, but responsible to both government and the people of Southwestern Ontario for planning, funding, and managing the overall health care system in the Region. They will encourage the participation of, and will work in collaboration with, service providers and the public in identifying and meeting the health care needs throughout the Region. This approach will only be successful if highly capable and experienced people are appointed to govern and manage the new Boards and high standards of performance are established.

The mandate of the new boards will not include the provision of service, nor the governance, management, or operation of individual service providers. The new governance structure will be designed to enhance, rather than diminish, the important role of service providers and their volunteer boards of governors, as well as facilitate the ability of service providers and the public to plan and obtain the necessary resources to meet the health care needs in each local area. The existing diversity of ownership of hospitals and other organizations will not be adversely affected by the new boards.

Southwestern Ontario Health Management Board

The Southwestern Ontario Health Management Board will be established as the regional authority with the mandate to ensure the effective and efficient delivery of health services in the Region. This Regional Board will be accountable jointly to the Government of Ontario, through the Minister of Health, and to the people of Southwestern Ontario.

The Southwestern Ontario Health Management Board will be charged with the following responsibilities:

- developing and implementing five-year strategic plans for the health system in the Region;

- developing and implementing a rational decision-making process for the allocation of annual operating funds throughout the Region from a total funding envelope provided by the Provincial Government;
- developing and implementing a rational decision-making process for allocating capital funds and approving capital expenditures;
- establishing regional health promotion and disease prevention goals and objectives;
- planning and managing human resources to meet the needs of the health care system in the Region;
- developing management reporting systems which are focused on measures of performance related to health outcomes;
- in cooperation with existing resources, developing an effective management information system;
- in cooperation with responsible institutions, ensuring the availability of resources to support coordinated health professional education;
- collaborating with and coordinating all segments of the health care system to ensure the delivery of a continuum of care, and
- implementing the 10-year plan developed for the Region by the Comprehensive Health System Planning Commission.

The Southwestern Ontario Health Management Board will also provide input to the Ministry of Health on the development of policies, standards and guidelines for health and health service delivery and research throughout the Province.

The Southwestern Ontario Health Management Board will be governed by an appointed board of directors representative of its constituency, managed by a Chief Operating Officer and include management and administrative personnel to carry out its responsibilities within the Region.

A Regional Governance Structure

Area Health Management Boards

In order to support needs-based planning and the development and management of the health care system at the community level, the Region will be divided into smaller geographic areas. The boundaries of these areas will be functional from a health planning and service delivery perspective and reflect the historical and political factors which have led to the creation of existing communities. The area structure will be based on balancing the need for keeping coordination requirements and administrative costs to a minimum, versus the need to support the capacity and responsibility of individual communities to establish their own health priorities and services.

The Southwestern Ontario Region will be comprised of six areas which coincide with the existing county geographic boundary structures in the following manner:

- Essex
- Grey-Bruce
- Huron-Perth
- Kent
- Lambton
- Thames Valley (Middlesex-Elgin-Oxford).

Each Area will be governed by an Area Health Management Board accountable to the Southwestern Ontario Regional Health Board. The Area Boards will be mandated to ensure the effective and efficient delivery of health services by the service providers within their respective areas. Their role in planning health services will be similar to District Health Councils; however, they will be significantly different insofar as they will be responsible for making decisions with respect to the allocation of operating and capital funds.

The Area Health Management Boards will operate within guidelines provided by the Southwestern Ontario Health Management Board and will have the following responsibilities:

- developing and implementing a revolving five-year operational plan for the health system in the Area;

- allocating operating funds from a funding envelope received from the Regional Board to service providers in the Area according to local needs and operational plans;
- supporting the Southwestern Ontario Health Management Board in making capital budgeting decisions for the Region;
- developing and implementing health promotion and disease prevention programs in the Area;
- creating opportunities and providing incentives for the amalgamation or rationalization of community and institutional services and service providers;
- participating in planning health professional education, and
- managing service provider performance, including the measurement of outcomes against plans.

The Area Health Management Boards will be governed by appointed boards of directors representative of their constituencies.

Regional Health Sciences Management Board

A Regional Health Sciences Management Board will be established with the mandate to oversee the tertiary care system in the Region. This Board will be accountable to the Southwestern Ontario Health Management Board and will be responsible for supporting the effective and efficient provision of services by the Region's health institutions and agencies involved in the provision of tertiary care and highly specialized services and facilities within and beyond Southwestern Ontario. It will have a board of directors which includes representation from the public, local government, and service providers throughout the Region.

The Heath Sciences Complex is a major focal point for tertiary care, education and research throughout the Region and is also highly esteemed as an important contributor to academic medicine, research, and the provision of tertiary care at a provincial and national level. In view of its primary and distinct role as a regional and extra-regional tertiary care resource, the Health Sciences Complex will report to the Regional Health Sciences Management Board which, in turn, will be responsible for supporting and enhancing all aspects of its role and function.

The Health Sciences Complex is also an important provider of primary and secondary care in London and the surrounding area which will be within the jurisdiction of the Thames Valley Health Management Board. The planning and coordination of primary and secondary care within the Thames Valley Area will be a complex and challenging task which will require the cooperation of the Regional Health Sciences Management Board, the Thames Valley Area Management Board and all service providers in the Area. In addition, in order to ensure that matters involving the Health Sciences Complex at both the regional and area levels are dealt with effectively, cross appointments between the Regional Health Sciences Management Board and the Thames Valley Health Management Board will be established.

Board Composition and Structure of the New Boards

Area and Regional Health Sciences Management Boards

Several alternatives for the composition of the Boards of Directors of the Area Health Management Boards and the Regional Health Sciences Management Board will be considered including:

Type of	**Alternative A**		**Alternative B**		**Alternative C**	
Representative	**No.**	**%**	**No.**	**%**	**No.**	**%**
Community	16	80	8	40	12	60
Service Provider	0	0	8	40	4	20
Local Government	4	20	4	20	4	20

Representatives for the Area Boards will be appointed from within their respective geographic areas while the Regional Health Sciences Management Board will draw its representatives from the entire Region. Committees will be formed to address specific issues such as health promotion policy and planning, finance, operations, and community liaison. In some cases, additional service providers will provide technical expertise to the Boards by serving on these committees. However, they will not be voting members of the Boards.

Southwestern Ontario Health Management Board

The Southwestern Ontario Health Management Board will be comprised of sixteen members including:

- one representative from each of the six Area Health Management Boards and the Regional Health Sciences Management Board;
- seven representatives from the community at large, and
- two representatives from the educational institutions involved in health education.

In appointing representatives for these Boards, particular consideration will be given to selecting individuals who bring a broad perspective on health issues and who represent the community at large rather than the interests of any particular group.

Committees of the Board will be formed to focus on specific management functions, such as:

- Planning;
- Finance, and
- Regional Services (for example tertiary care and psychiatric care).

Representatives of the health service providers will participate on these board committees. Additional committees will be formed to address internal operational issues, such as financial auditing.

An Educational Advisory Group will be created to support the Southwestern Ontario Health Management Board on matters relating to the utilization of the resources of the entire Region in planning, developing, and facilitating health education and training for health professionals of all stripe. The Educational Advisory Group will be responsible for liaison with universities, community colleges, and health service organizations in the Region as well as with the Regional Health Sciences Management Board and Area Boards. This group will be comprised of representatives from educational institutions, the Regional and Area Health Management Boards, and other representatives including, but not limited to:

- health disciplines;
- community health home care, and
- public health.

A Utilization Review Board will be established to review the utilization of physicians and other health professionals. This Board will act as an independent arm of the Southwestern Ontario Health Management Board.

Board Appointments

An important, on-going challenge for the new system will be the maintenance of dynamic and effective boards through the appointment of competent, unbiased individuals who can represent current views and needs of the public.

The initial boards of directors for the Southwestern Ontario and Area Health Management Boards and the Regional Health Sciences Management Board will be appointed by Order-in-Council in order to:

- ensure a balanced representation of individuals with a broad perspective of health;
- ensure that board members have the necessary qualifications to initiate the operation of the authorities, and
- provide the Provincial Government with overall control of the budget allocated to the Region.

A review of the method of appointment of board members will be undertaken within three to five years of the initial formation of the Southwest Ontario Health Management Board. Along with other matters at that time, consideration will be given to replacing some or all of the service provider representatives with appointments from the community at large made by the Board of Directors.

Compensation for Board Members

As appointed representatives in a system which is accountable for the management of up to $2 billion to $3 billion of public funds, a significant investment of time will be required. Therefore, members of the new boards of directors will receive compensation based on an assessment of fair and equitable remuneration for positions in comparable organizations.

Accountability of the New Boards

Mechanisms will be established to ensure that the new boards are held fully accountable to the residents of Southwestern Ontario and to the Government of Ontario. These mechanisms will include the following:

- meetings which are open to the public;
- published annual reports;
- special annual public meetings to present future plans and priorities and to review operating and financial performance;
- evaluation of board performance against specific standards of performance;
- audited financial statements, and
- a rigorous appeals process whereby major planning, operating and capital decisions can be reviewed at the Area Board or Regional Board level.

Service Providers

Under the new system, service providers such as hospitals, Boards of Health and other community agencies, will be accountable to the respective regional or area management boards from they will receive planning guidelines and budgetary allocations. In turn, the new boards will be responsible for supporting and enhancing the roles of service providers. The appointed boards of service providers will continue to have the traditional responsibilities of governing boards such as:

- establishing and implementing the organization's purpose and mission;
- setting the rate of progress which the organization will undertake in achieving its purpose or mission;
- providing continuity for the governance and management of the organization's affairs, and
- confirming the organization's identity within the community it serves.

In the future, these responsibilities will be carried out in closer collaboration with other service providers, particularly with respect to establishing and achieving each organization's mission in a manner which contributes to the overall effectiveness and efficiency of the health system.

District Health Councils

The contribution and commitment of District Health Councils to improving health care in the Southwestern Ontario Region for over a decade is widely recognized. Valuable resources exist within the District Health Councils, including experience and expertise in health care planning and coordination, knowledge of Ministry of Health systems and procedures, and knowledge of health care needs within the Region. The existing volunteer and staff resources and operating budgets within the District Health Councils will be incorporated into the new Regional and Area Health Management Boards. In this way the benefits of the experience and expertise which exist in the District Health Councils can be utilized without additional costs for the administration of the system.

Mental Health

A wide range of service providers in Southwestern Ontario are involved in the provision of mental health services, either as a raison d'être or as one aspect of their mission. The organizations devoted to mental health include the Region's two psychiatric hospitals, children's mental health centres and a variety of other community agencies. Mental health has long been a significant area of concern within the health system and has been the subject of previous studies including the Graham Report.

Currently, a plan is being developed through the District Health Councils in the Region in an effort to identify and meet mental health service needs in a coordinated fashion.

Mental health services are an integral part of the health system and cannot be managed in isolation. Accordingly, they will be an important constituent which is managed through the new Regional governing structure. The two psychiatric hospitals are currently governed and operated by the Ministry of Health as part of the provincial psychiatric hospital system. In keeping with the principles and potential benefits of establishing regional governance, the psychiatric hospitals will no longer be managed directly by the Ministry of Health. In view of their role as regional resources, these hospitals will be overseen by the Regional Health Sciences Management Board. Separate institutional boards of directors will be established for their individual governance.

> *"More persons will suffer from mental illness than those who will have heart disease or cancer problems combined ... poor mental health is often related to physical illnesses."*
>
> Canadian Mental Health Association
> Windsor-Essex County Branch
> Commission Public Consultation Process
> September to October 1991

Joint Ministry Community Health and Support Services Division

In 1990, as part of the Provincial Government's process for Long-Term Care Reform, the Ministries of Health and Community and Social Services established a joint division to administer and

A Regional Governance Structure

coordinate long-term care services from both Ministries on a decentralized basis throughout the Province. A total of fourteen long-term care Area Managers were established across Ontario, including three of these managers who have area responsibilities which include the Southwest Region.

The provision of long-term care is an integral part of the health care system in Southwestern Ontario. Under the regional system of governance, the responsibility for long-term care will be assigned to the Area Health Management Boards. The existing structure and accountabilities of the joint Community and Social Services Division will be modified and incorporated within the Area Boards.

A Framework for Community Input

The achievement of improved health in Southwestern Ontario will require the delivery of a continuum of health services which is specifically designed to meet the special needs of people in each local community. Individual citizens must therefore have a greater say in the determination of services which are provided in their local areas. Furthermore, with the continued difficulties in meeting growing health needs within limited funding resources, it is important that there is public input into how the health care dollar is allocated and what trade-offs in services are required to meet local health priorities.

The efforts of formally established committees and groups involved in planning and developing health services will be supplemented by input from "natural communities" – groups of people who share common interests around specific health issues. Natural communities are groups such as the hearing impaired, AIDS committees, and the Low German-Speaking Community. Representatives of natural communities will act in advisory roles in identifying health needs and issues, establishing health planning priorities and providing feedback on existing services.

The Area Health Management Boards will be responsible for encouraging new program and service initiatives from natural communities. Each Area Health Management Board will have a Community Development Worker on staff who is responsible for providing support and guidance to community representatives.

A Changing Role for The Ministry of Health

Under the new system of regional governance, the Ministry of Health will continue to discharge its current mandate for overall funding of the health care system and development of legislation, policies, and standards relating to the provision of health care services and of consistent and appropriate health education and research across the Province. The Regional and Area Health Management Boards will be responsible for ensuring that the health care system within their respective areas of jurisdiction meets national and provincial health guidelines and standards.

The Ministry will also need to ensure that the total distribution of funds to the Southwest Region is fair and equitable vis-a-vis the needs of people in the rest of the Province. It will also assist the Southwestern Ontario Health Management Board in fulfilling its role and measure its performance. With a new focus on broad health system governance, the Ministry will have the opportunity to undertake a more proactive approach to the development of government policies which address social, economic, and environmental concerns as well as basic health care issues.

Coincident with the devolution of its responsibilities, the administrative operations and operating budget of the Ministry of Health will be reduced on a basis equivalent to the establishment of administrative resources and costs at the regional and area levels in Southwestern Ontario. In this process, consideration will be given to a "one-to-one" replacement of existing resources and costs. In this way, there will be no new administrative costs or additional layers of bureaucracy added to the system as a result of devolution.

Operating Funding

In order to provide the necessary flexibility to the Region to make funding decisions based on need, the existing funding system at the Provincial level will be changed. In place of the current system whereby allotments of funding for the different categories of health care spending are voted on separately by the Provincial Legislature, there will be one "vote" for health care in Southwestern Ontario. A horizontal system of funding will replace the current vertical system. The basis for determining the size of the vote will be "need" or the ability of the population to benefit from the health services provided. Need will be defined in per capita terms with adjustments for age, sex, and referral patterns. Consideration will be given to adopting a formula for funding on this basis, such as the proposed model which is being developed by the Centre for Health Economics and Policy Analysis at McMaster University in Hamilton, Ontario.

Under this new funding arrangement, the Regional and Area Health Management Boards will have the capability to establish local priorities, make decisions between competing demands, provide better health care, and contain the rapid increase in health care expenditures.

The total funding provided to the Southwestern Ontario Region under the proposed system will likely be similar to that under the current system. The major difference between the two approaches will be the ability of the regional authority to allocate funds according to health needs and priorities within the Region without approval from Queen's Park.

Capital Funding

The management of capital expenditures will be devolved to the Southwestern Ontario Health Management Board and consideration given to integrating the current and capital accounts at the local level. In its decision-making on capital projects, the Southwestern Ontario Health Management Board will utilize a capital planning model which considers the cost of capital over the life of a project.

Health Education and Research

Funding decisions for health education and research will remain at the Provincial level and funds for these purposes will flow through intact to the institutions involved. In particular, the responsibility for funding the educational and research responsibilities of the Health Sciences Complex, primarily discharged by the members of the Faculty of Medicine of the University of Western Ontario, will remain with the Government of Ontario acting through the requisite Ministries. The University will continue to relate directly to those Ministries in these respects. Should an alternative funding plan be introduced which includes the funding of associated clinical service now derived from OHIP directly by clinical teachers, those funds will continue to be managed under a contract directly with the Government of Ontario.

Although the Southwestern Ontario Health Management Board will be concerned with accommodating education and research activities within the Region, it will not have responsibility for providing policy direction and financing the personnel who provide education and research within Southwestern Ontario. It will, however, have authority and responsibility for making available for the purposes of education and research, all elements of the health services system in Southwestern Ontario and will be provided with funds for this purpose. The Educational Advisory Group will play a direct liaison role with educational institutions in this process.

Local Government Funding for Public Health

Under the new system of governance and management, public health programs which are currently the responsibility of local government will be overseen by the Area Health Management Boards. Boards of Health will be accountable to the Area Health Management Boards for their role in public health protection, health promotion and disease prevention. The municipal contribution of 25 percent of mandatory health programs will be transferred from the Municipal

> *"The concept of 100% funding of public health programs is seen as a positive change."*
>
> Elgin-St. Thomas Health Unit
> Commission Public Consultation Process
> September to October 1991

real property tax base to the Provincial tax base and become part of the funding envelope for the Region which will be received from the Ministry of Health.

THE PLAN: TOWARDS BETTER MANAGEMENT OF OUR HEALTH

Summary

Health promotion and disease prevention will be crucial in improving the health of the people of Southwestern Ontario and keeping the costs of the health system under control. Realization of the Ontario Government's health goals through a community-oriented approach to health promotion and disease prevention, as recommended by the Premier's Council on Health Strategy, is a key objective for the Southwestern Region.

The development of health promotion and disease prevention programs will be based upon the following principles:

- direct involvement of people in decisions affecting their health;
- development of stronger family and community supports which enable individuals to maximize their potential for good health within their own homes and communities;
- improvements to the societal and environmental factors which determine health and illness, and
- the use of a wide range of approaches, such as education, legislation and community development policies.

These principles will be applied through a structured planning process which focuses on:

- development of healthy children;
- reduction of coronary heart disease;
- promotion of healthier workplaces;
- prevention of substance abuse;
- development of increased health promotion knowledge and skills, and
- coordination of health and environmental planning.

The Southwestern Ontario Health Management Board will be responsible for setting regional health promotion and disease prevention goals and priorities, for providing health promotion

THE PLAN: TOWARDS BETTER MANAGEMENT OF OUR HEALTH

Summary

funding envelopes to the Area Health Management Boards and for monitoring the progress in achieving improved health throughout the Region. The Area Health Management Boards will be responsible for working with community and other agencies which will provide promotion and disease prevention programs within their respective areas.

Health promotion and disease prevention planning will be community-oriented and based on local needs identified through consultation with the community. Communities will play a greater role in improving health through their local Boards of Health. To facilitate this process, each Area Health Management Board will have a health promotion committee which includes representatives from service providers, local government and consumers.

In order to support these efforts to improve health, increased funding will be provided. Over the next ten years, an additional one percent of total health care system spending will be allocated to health promotion and disease prevention from within the funding envelope provided to Southwestern Ontario.

What Are Health Promotion And Disease Prevention?

Health promotion is an approach which is intended to help all people to improve their health by influencing the environment in which they live. Health promotion is a mediating strategy that seeks to enable an individual to become healthier by influencing both personal choice and social responsibility for health.

Disease prevention is aimed at reducing the risk of acquiring a disease. It is largely concerned with individuals - reducing the risk of disease and preventing illness. It may involve both sanitary measures such as sewage treatment to prevent infectious disease, and the encouragement of lifestyle changes, such as not smoking to prevent lung cancer.

The prevention of disease and the promotion of healthful living standards are mutually beneficial concepts, and are usually complementary strategies for addressing health issues.

According to the Ontario Ministry of Health, there are four key components to any comprehensive health promotion and disease prevention program:

- **Health Enhancement** - increasing the level of good health, vitality and resilience in all people;
- **Risk Avoidance** - ensuring that people at low risk for health problems remain at low risk;
- **Risk Reduction** - with respect to moderate or high-risk characteristics among individuals or segments of the population, and
- **Early Identification** - increasing the awareness of early signs of health problems and screening people at risk in order to detect the early onset of health problems.

Existing Programs

Health care institutions, a wide range of community service agencies, public health units and home care providers are making important contributions to existing health promotion efforts in Southwestern Ontario. There are many community-based health promotion and disease prevention initiatives in the Region. Most of these projects are funded through the Government of Ontario and Health and Welfare Canada. These programs include such diverse initiatives as:

- **Women Today**, a program of mutual aid groups for rural women in Huron County;
- **Substance Abuse Prevention** programs in fifteen communities throughout the Region;
- **Rural Health Promotion** projects in Grey, Bruce, Perth and Oxford Counties;
- **Health Promotion In The Workplace** programs offered by a number of employers in the Region;
- **A Community Approach to AIDS** by the AIDS Committee of London;
- **Better Beginnings**, a province-wide program for healthy child and family development;
- **Healthy Aging** program in Woodstock to promote healthy and safe environments for seniors;
- **Multicultural Health** projects through the London Intercommunity Health Centre, and
- **Healthy Lifestyles** programs including nutrition education among low-income families.

In addition to these formal programs, there are many other activities which foster health promotion and disease prevention, such as school health programs, media advertising of health issues, fluoridation of water, and advice from physicians and other health professionals.

Guiding Principles for Promoting Health

The implementation of programs for improving the health of the people of Southwestern Ontario will be based on the adoption of the following guiding principles which have been developed for consideration in the plan on the basis of previous studies in Ontario and Canada as well as the World Health Organization:

Involve people in improving their health.

- Empower people to make informed decisions about their health; focus on increasing autonomy and personal skills.
- Assign authority for decision-making and resource allocation as close to the individual as possible.
- Ensure public participation in the planning and implementation of health initiatives.
- Promote healthy lifestyles and personal accountability for individual behaviour, while recognizing that personal choice may be limited by one's social and physical environment.

Strengthen families and build a supportive community.

- Strengthen the ability of families and friends to promote health by providing supports within the community.
- Recognize everyone's potential to improve their physical, mental, social, and spiritual dimensions of health, including those who are disabled or chronically ill.
- Augment community services and ensure collaboration between local health and social services.
- Reorient health care toward a greater emphasis on disease prevention and health promotion.

Focus on the societal and environmental factors that determine health and illness.

- Build an explicit concern for health, equity and sustainable development into public policy.

- Reduce social inequities by targeting programs, services, and resources to disadvantaged groups, especially when resources are scarce.
- Ensure that policy makers understand the impact on health of their decisions in other sectors such as housing, transportation, agriculture, and income maintenance.

Employ a wide variety of approaches to promote health.

- Use community development techniques to encourage communities to organize and draw upon their resources to support health.
- Use complimentary and diverse approaches such as social marketing legislation, fiscal measures, information and education, public participation, advocacy, and organizational change.
- Assess the scientific validity of proposed interventions in disease prevention and ensure that evaluation is a component of every health promotion initiative.

A Structured Planning Approach

The matrix model proposed by the Health Promotion Branch of the Ministry of Health for improving health will be adapted and used to plan and coordinate health promotion and disease prevention programs in the Region.

This approach will be applied to the specific needs and health priorities of each community throughout Southwestern Ontario. The broad definition of health will be applied in identifying the issues to be addressed in each community. Through this planning process, health promotion will become an integral part of the planning and delivery of health services in the Southwestern Ontario Region.

Spectrum of Needs

In 1987, the Addiction Research Foundation proposed a comprehensive approach for dealing with people with alcohol and drug abuse problems. This approach involves the combined application of health promotion, disease prevention and health recovery techniques. It emphasizes health promotion and disease prevention, while at the same time ensuring that complementary health recovery services are in place. This conceptual approach to addressing the spectrum of health care services will be adopted in health promotion and disease prevention efforts in conjunction with enhancement of community services in Southwestern Ontario.

Research And Evaluation

Community health promotion programs will be routinely evaluated in terms of their progress toward chosen targets. This process will enable the refinement of methods and the identification of successful strategies for potential application in other communities.

The research and evaluation process will require the on-going development and analysis of data with respect to health status and health-related attitudes, knowledge and behaviour at all levels. The Ontario Health Survey will provide important baseline measures of health status. The Ministry of Health will be encouraged to repeat this process every five years. In addition to health-related information, the research and evaluation process will include the development of other measures of health and quality of life in a community, such as unemployment statistics, literacy levels, and admissions to social service agencies.

The methodology used for evaluating health promotion will be specific to the nature of the individual program and its goals. A wide range of approaches will be required. Analysis and testing of various methodologies will be carried out.

To facilitate the evaluation of health promotion programs and research into evaluation techniques, the Southwestern Ontario

Health Management Board will administer a health promotion research fund from within the total envelope of funding allocated to health promotion and disease prevention.

Healthy Child Development

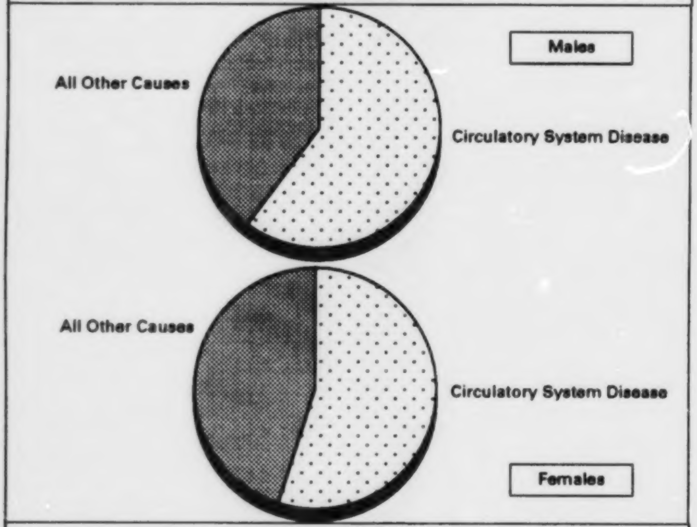
In 1989, the "Ontario Child Health Study", conducted by McMaster University and Chedoke-McMaster Hospitals in cooperation with Statistics Canada, documented, particularly in disadvantaged families, an alarming number of children who are likely to experience emotional and behavioural disorders. In recognition of the importance of this issue, a number of pilot programs are underway in the Region, including a Better Beginnings, Better Futures project on Walpole Island, Helping Children Adjust, with the Lambton County school boards and Healthy Mothers; Healthy Babies at the Sandwich Community Health Centre in Windsor.

Health and well-being in early childhood affect the development and acquisition of skills essential to good health and success in later life. The implementation of programs to enhance the health of children will be given high priority throughout the Region, particularly, given the socio-economic patterns of lower income, higher unemployment and greater numbers of single-parent families in certain parts of Southwestern Ontario compared with the entire Province. Increased prenatal education, the prevention of low birth weight babies and mental health promotion will be considered. In addition, other contributing factors from outside the health care system will be examined. Parenting skills, quality child care, comprehensive school health, family functioning, child poverty and child abuse, and skill development for disadvantaged children all require attention.

Heart Health

Circulatory system disease, including coronary heart disease, stroke, and other forms of heart disease, is the number one cause of death in Southwestern Ontario. Despite significant declines in mortality rates from heart disease over the past few decades, circulatory system disorders, and particularly ischemic heart disease, are significantly elevated in both males and females in all age groups in Southwestern Ontario in comparison with the rest of the Province. An integrated, comprehensive cardiovascular disease control program will be established for the Region. This initiative will also be designed to have a positive influence on risk factors for cancer and diabetes (diet, smoking, weight management, and exercise). Resources for this program will be allocated in each Area and programs linked with region-wide plans.

Causes of Death in 1988



Source: Disease-Specific Mortality Trends in Southwestern Ontario
Robert J. Alder and Stephanie R. Loomer

Employment and Health

The Premier's Council report "Nurturing Health" pays special attention to the links between health, work, and occupational environment. Unemployment can exacerbate problems such as substance abuse and family violence, and lead to an increase in suicides. With approximately 67 percent of Southwestern Ontario residents over 25 years of age currently employed in the workforce, dealing with these problems is a high priority for the Region.

The Region also has some specific health problems due to the nature of its workforce. With the highest combined percentage of the workforce employed in the primary and manufacturing sectors of any Region within Ontario, there is a higher than average risk of accident and injury.

Short and long-term benefits can be derived from workplace health promotion programs. Studies have shown, for example, that these programs can lower rates of absenteeism, reduce health care costs and increase morale.

Using Health and Welfare Canada's suggested strategies as a guide, employers will be encouraged to achieve a healthier and more productive workplace environment.

In rural areas there is also a need to promote a healthy environment for farm families and farm workers, particularly among disadvantaged workers. Areas such as Grey County, in which family incomes are significantly below the Provincial median, also require special attention.

Preventing Substance Abuse

Efforts to reduce the use of tobacco, alcohol and illicit drugs and to eliminate the excessive use of prescription drugs have been identified as high priorities by all existing District Health Council plans in Southwestern Ontario. The lack of assessment and treatment centres also continues to be a problem for the Region. Adolescents in particular are often referred to Michigan and other centers in the United States for treatment.

The Region will continue to deal with substance abuse, giving priority to such initiatives as reducing smoking among young women, reducing alcohol-related motor vehicle accidents, facilitating Aboriginal Peoples' programs to prevent substance abuse and increasing the awareness of excessive drug use by seniors. Particular attention will be given to determining the need for regional assessment and treatment centres for adolescents.

> *"At least 1,000 London youth are addicted to alcohol, cocaine derivatives such as crack and ice and other illicit drugs. A 25 percent increase is expected over the next two years."*
>
> The Raoul Wallenberg Centres Inc.
> Commission Public Consultation Process
> October to November 1990

Knowledge and Skill Development

If resources allocated to health promotion and disease prevention are to be well used, the capacity and infrastructure for health promotion and disease prevention in Southwestern Ontario must be enhanced. This includes efforts to increase health-related knowledge and skills among the public, providers, and decision-makers. Following the lead of some District Health Councils in the Region, resources will be made available for community development initiatives, educational projects, training workshops, and for programs to build skills in advocacy, needs assessment and evaluation.

Coordinated Health and Environmental Planning

The Premier's Council has proposed a number of objectives and targets leading towards its goal to "Ensure a safe, high quality physical environment". While a comprehensive approach to this issue is important, one target has particular relevance to health promotion: the need to link health and environmental concerns in community planning. The coordination of planning between health authorities and those responsible for environmental planning is essential at all levels. For example, municipalities have responsibility for a number of areas concerned with the environment and its impact on human health, such as solid waste management, land use planning, and municipal water and sewer use.

Ontario contains over half of Canada's Class 1 farmland. More than twice as much of Southwestern Ontario's labour force activity is devoted to farming than in Ontario as a whole. The Southwestern Ontario Region will work with farmers in rural communities to create agricultural systems that benefit both human health and the environment.

A mechanism will be put in place to ensure coordinated health and environmental planning. Amendments to The Planning Act may be necessary with the establishment of permanent community advisory committees.

Southwestern Ontario Health Management Board

In its overall role as the coordinating body for the health system in the Region, the Southwestern Ontario Health Management Board will be responsible for setting regional health promotion and disease prevention goals and priorities, for monitoring progress in meeting these goals, and for allocating funding to the Area Boards and relevant programs. It will also support the Area Health Management Boards through the coordination of area efforts on a regional basis and undertake region-wide promotional efforts in such areas as knowledge development, public information programs, education for professionals and training and research.

> *"Health promotion is the process of enabling individuals and communities to increase control over the determinants of their health. Health promotion represents a mediating strategy between people and their physical, social and economic environments, combining personal choice with social responsibility for health to create a healthier future."*
>
> Lambton Health Unit
> Commission Public Consultation Process
> October to November 1990

The Southwestern Ontario Health Management Board will include a Health Promotion Division of at least three people with expertise in needs assessment, education and training, community development, planning and intersectoral policy development. In addition to coordinating regional initiatives, the Health Promotion Division will provide support to the Area Health Management Boards.

To ensure that the promotion of health and the prevention of disease is coordinated throughout the Region, the Southwestern Ontario Health Management Board will review regional health data and area priorities and re-establish regional priorities every five years. This Board will also stimulate local initiatives for addressing regional priorities, under the umbrella of a coordinated regional effort.

The Southwestern Ontario Health Management Board will also facilitate information sharing by publishing health promotion initiatives and serving as a clearinghouse for material produced in specific areas within the Region. It will monitor progress in the achievement of established health goals for Southwestern Ontario and produce a report every two years on the health status of the people in the Region.

The adoption of a goals-oriented, community-based planning system will involve social and environmental issues, such as shelter, income and employment, which are beyond the jurisdiction of the health care system. In order to achieve a coordinated approach to health issues on a broader level, the Southwestern Ontario Health Management Board will take a lead role in forming broadly representative committees able to engage the many groups which influence the regional environment bearing upon health. These committees will include representatives from such areas as local government, private industry, education, the environment, recreation, and social services.

Area Health Management Boards

The Area Health Management Boards will be given the responsibility to:

- identify health needs in their area and develop annual plans which include local goals, targets, and priorities;
- coordinate health promotion and disease prevention activities within their district;
- allocate funds to health promotion and disease prevention initiatives, and
- monitor progress toward the achievement of these health goals.

A health promotion committee will be established in each Area to advise the Area Health Management Board on health promotion and disease prevention issues. This committee will include representation from providers and the public, particularly from those groups who are targeted for health promotion initiatives. In order to facilitate this process, each Area Health Management Board will have a designated staff person for health promotion and community development.

Local Government

Communities within Southwestern Ontario will be supported in their initiatives to become more healthy. Health units will play a major role in identifying, planning and coordinating local initiatives which are tailored to local needs, but are also in keeping with the health promotion and disease prevention priorities for the entire Region. Local communities will be assisted in creating and supporting mutual aid groups, voluntary organizations and other health promotion activities involving local government, schools, employers, and recreational groups that improve health in local neighbourhoods and the workplace.

Increased Allocation of Health System Funding

The promotion of good health and the prevention of disease have significant benefits for the health status of the population. However, the total amount of money being spent on these activities is miniscule when compared to the costs of treating illness. While there is a clear need to constrain the overall growth in health care spending, more of the health care dollar needs to be allocated to efforts that will enable people to improve their health.

In order to improve health promotion and disease prevention programs, additional funding will be allocated from within the total health system budget for Southwestern Ontario. Over the next ten years, an additional one percent of health care spending in Southwestern Ontario will be allocated to health promotion and disease prevention. In terms of the total estimated 1990/91 spending on health care in Southwestern Ontario, this represents approximately $22 million.

The 1989 Mandatory Health Programs and Services Guidelines have provided that Boards of Health and Health Units take a leadership role in promoting health, preventing disease and injury, controlling threats to health and facilitating social conditions to ensure equal opportunity for health. Health Units will be fully funded by the Area Health Management Boards to implement these programs.

A separate fund will also be established at the Regional level from within the total funding devoted to health promotion and disease prevention for innovative projects and for coordinating local area projects which meet Regional needs. A health promotion

Management of Community-Oriented Health Promotion

contribution fund for projects sponsored by community groups will be established and administered by the Area Health Management Boards. A portion of the funds will be dedicated to disadvantaged groups based on need. On-going funding will be provided for project work and a portion of the fund made available for sustaining grants to community groups devoted to health promotion and disease prevention.

The Health Care Team

In order to implement improved health promotion and disease prevention successfully in Southwestern Ontario, additional specialist resources are required. In addition, the traditional roles of physicians, nurses and allied health care providers need to be changed.

Specialists in Health Promotion and Disease Prevention

In future, there will be the need for more specialists in health promotion and disease prevention in order to support the initiation of community efforts and the mobilization of community resources.

Physicians

The family physician's role in health promotion and disease prevention is to provide guidance for families and individuals as they move through the life cycle, identify and manage high risk individuals and detect and treat disease in all stages. Physicians in all specialities can play an important advocacy role with respect to such issues as family violence, substance abuse, industrial safety, environmental issues, water fluoridation and motor vehicle safety.

Several initiatives will be undertaken to enhance the role of physicians in health promotion and disease prevention. Physicians will be provided with additional training in health promotion and the broad determinants of health. Opportunities for interdisciplinary work in the community or in clinical settings will be increased. The potential for making adjustments to the existing fee-for-service schedule to provide appropriate reimbursement for preventive services and for work with community agencies will be examined. The implementation of any such adjustments will require the agreement of the Provincial Government and the Ontario Medical Association.

Nurses

Nurses in community, workplace and health care settings are well placed to enable individuals to take control over their health. There is significant potential to expand the existing role of nurses in health promotion and disease prevention. This role will be reviewed and revised in cooperation with health service providers in the Southwestern Ontario Region.

Other Health Care Providers

Other health care providers, such as dietitians, pharmacists, physiotherapists and homecare workers, bring complementary and important skills to the health promotion and disease prevention team. Each will play an increased role in education and in facilitating community-initiated projects.

Social service providers and recreation professionals who have not traditionally been part of the health care team will also play an important role in health promotion. Similarly, the voluntary sector in health and social services will continue to be a significant contributor to health promotion and disease prevention initiatives.

Hospitals

With greater emphasis on community-based services and ambulatory care, the traditional role of hospitals in treating the sick will be expanded. The hospital's role in the community will involve hospital-based community education and outreach services which ensure a continuum of care from the hospital to the community. Hospitals will also be encouraged to collaborate with community agencies and groups in the development of alternative models of care to be provided by home care, public health teams, recreation programs and self-help groups.

Educational Institutions

Elementary and Secondary Schools

Comprehensive school health programs involving children, young people, parents, teachers and other members of the community will be encouraged to make schools more effective centres for community health promotion. These programs will include health instruction and health and social services supports.

Universities and Colleges

Universities and community colleges in the Region will be encouraged to review their current health sciences programs with the objective of providing more interdisciplinary experience and increased exposure to health promotion, disease prevention, health economics and the determinants of health. Retraining for health professionals already working in the field will also be encouraged. University researchers will work collaboratively with service providers and community groups in the evaluation of health promotion and disease prevention programs. The newly established Middlesex-London Teaching Health Unit will provide leadership in teaching and research with respect to related public health issues throughout the Region.

Family Members

Family members and other informal caregivers are particularly vulnerable to chronic fatigue and stress associated with caring for ill or disabled family members, while trying to raise a family and participate in the workforce. These individuals will be given assistance in fulfilling these roles through such means as increased respite care, financial assistance, and a range of professional and non-professional support services.

THE PLAN: TOWARDS BETTER MANAGEMENT OF OUR HEALTH

Changing Roles and Responsibilities

The Community

Community development – the establishment, growth and redevelopment of communities – is characterized by public participation at all stages. It also requires leaders with experience and knowledge of the community development process. Traditionally, this leadership has been provided by voluntary leaders in the community and social service workers. Health agencies in the Region will work collaboratively with community leaders, social service agencies and educators in the community development process to ensure that health needs and issues are taken into consideration.

THE PLAN:
TOWARDS BETTER MANAGEMENT OF OUR HEALTH

Summary

Following on the recommendations of the Premier's Council on Health Strategy, the enhancement of health care services which are provided in the home or in the local community is a strategy which will be adopted to support the achievement of the long-term goals for improved health in Southwestern Ontario. The new regional system of governance, the envelope system of funding and the increased emphasis on health promotion and disease prevention will overcome many of the obstacles which have impeded the development of community services in the past. In addition, specific measures will be implemented to support the enhancement of community services where they can contribute to improved health and are cost effective. These measures will include the establishment of a spectrum of viable services in each community based on needs, together with initiatives to facilitate training and attract the necessary health professionals to provide these services.

In order to finance these efforts, and following the guidelines proposed by the Premier's Council on Health Strategy, the share of total health system funding devoted to community services will be doubled over the next ten years. The Area Health Management Boards will encourage collaboration among providers of community services in order to avoid duplication or fragmentation of services and to ensure that the funding for community services is spent effectively. Both the Regional and Area Boards will oversee on-going research into, and evaluation of, the health outcomes and cost-effectiveness of community services.

Coincident with an increased emphasis on community services, the existing reliance on institutional services will be reduced. Acute care hospital services will be rationalized throughout the Region through increased measures to reduce the utilization of hospital beds. In order to provide more accessible hospital care, the capability of certain community hospitals to provide secondary acute care services will be increased.

The Health Sciences Complex will be encouraged to build upon its current joint strategic planning efforts by establishing an integrated strategic plan and developing effective systems of collaborative governance and management of services and resources. To support the decentralization of secondary acute care services, the institutions of the Health Sciences Complex will also be encouraged to rationalize their services. The Complex will be asked to support the establishment of more broadly-based health education and research programs in both institutional and community agency settings throughout Southwestern Ontario.

In conjunction with the Provincial Government's initiative to redirect the provision of long-term care services in Ontario, a major emphasis in the enhancement of community services will be placed on services for the elderly and physically disabled. Support systems for the delivery of services in people's homes and in the community will be increased and the use of institutional settings for long-term care will be reduced in order to provide more accessible and better quality services within the community and the home, while helping to curtail the rapidly growing costs of care for the elderly and disabled.

Introduction

As described in a background study commissioned by the Health Care System Committee of the Premier's Council on Health Strategy, community services can be defined as services which:

- focus on the independence of the individual, local health needs and the improvement of health;
- are provided in the home or in the local community;
- are planned and managed by the local community and the service providers who are accountable for the results achieved, and
- are provided by agency staff and volunteers.

Community services span a wide range of health care needs from the prevention of disease and the maintenance of good health, through the provision of short-term assistance to individuals recovering from illness or injury to long-term support for the elderly and the physically disabled. Over the past several years, the development of community services in Southwestern Ontario has focused largely on meeting the increasing needs of the elderly and the physically disabled. However, community services have the potential to benefit all residents of Southwestern Ontario, regardless of age or health care needs.

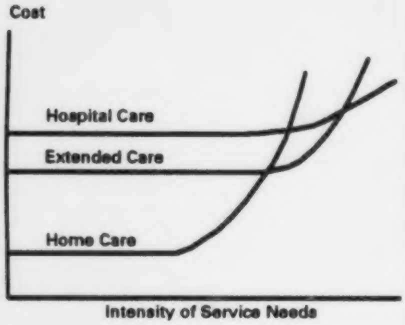
The Potential Role for Community Services

Over the past two decades, numerous studies in Ontario and Canada have concluded that the enhancement of community services is a desirable strategy for improving the delivery of health services. The rationale put forward is their potential to provide integrated and coordinated services which are responsive to the total health needs of the individual and the local community. Community services are also viewed by health care planners as an effective focal point for improved health promotion and disease prevention programs, and by the recipients of care as providing a more desirable setting for health care than institutions.

"It is widely recognized that both the individual and the community benefit when people are able to remain in their own homes in health and safety and can enjoy as much independence as their circumstances allow. Many, however, need assistance in achieving this goal and when it is not provided by family, friends or in other ways, they must look to the community for the support they require."

Meals on Wheels, London
Commission Public Consultation Process
October to November 1990

Comparison of Cost versus Intensity for Alternate Modes of Service Delivery



Source: Health Care System Sub-Committee, Premier's Council on Health Strategy

The Relative Costs of Community Services

There is considerable debate and uncertainty over whether community services are more or less costly than institutional care. To-date, there has been no definitive study of the relative cost effectiveness of community and institutional services. However, according to the background paper to the Premier's Council, at low levels of service intensity, home-care can be provided at lower cost than institutionally-based care, due to a lower investment in fixed costs for buildings, land and equipment, while at higher levels of intensity, institutional care becomes more cost effective as the labour costs for providing home visits by health professionals outweigh the cost advantages of the concentration of services in an institutional setting. This comparative cost relationship must be considered in any effort to enhance community services in order to ensure that a balance between service and cost effectiveness is achieved.

Enhanced Community Services as a Long-Term Strategy for Southwestern Ontario

Over the past few years, there has been a significant increase in the delivery of health care through community services. For example, integrated homemaker programs have been established in many areas throughout Southwestern Ontario. However, these and other community services need to be extended to all areas in the Region. Furthermore, a lack of coordination of efforts among the wide array of independent community service agencies has led to fragmentation of services and cost inefficiencies in such areas as community mental health and long-term care.

The enhancement of community services is a strategy which will be adopted to support the achievement of the long term goals for improved health in Southwestern Ontario. It must be recognized that the implementation of this strategy will require an investment of significant operating and capital resources in order to develop an effective and efficient infrastructure of health professionals and facilities.

It is also important to note that the coordination between institutional and community services needs to be improved and the involvement of health care institutions in community services more clearly defined. For example, institutions will play a significant role in the development of community services through collaborative efforts with community agencies, and hospitals in smaller communities may become involved in the direct provision of service. Such services also need to be in place in order for the rationalization of institutional services to occur.

New Foundations for Service Enhancement

New groundwork for the development of community services will be laid through other initiatives in the plan, including the establishment of a regional system of governance which encourages local initiatives and the increased emphasis that will be placed on health promotion and disease prevention programs. It is clear from the earlier findings of the Premier's Council that these initiatives have the potential to overcome many of the obstacles which have impeded the development of effective and efficient community services throughout Ontario in the past.

The Southwestern Ontario Health Management Board will be responsible for providing overall direction for the management and development of community services throughout the Region. The other boards will be responsible for facilitating community representatives and service providers in planning, developing and coordinating community services which meet the specific needs of local communities in a cost-effective manner. The envelope system of funding from the Regional to the Area level will provide the financial framework for integrating community services with other health services and for managing the overall costs of community services.

One of the purposes of the increased funding allocated to health promotion and disease prevention programs will be to help finance educational programs to increase public awareness of the role of

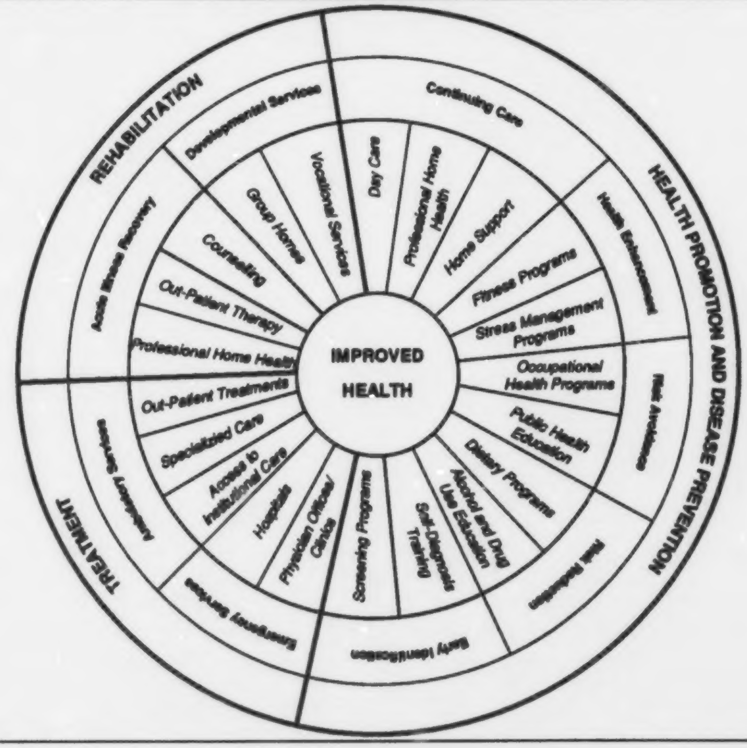
> *"Prior to any transition from institution to community there is a definite need to ensure appropriate and adequate community support choices are in place."*
>
> **Victorian Order of Nurses for Oxford County**
> **Commission Public Consultation Process**
> **September and October 1991**

community-based services in the improvement of health and in the appropriate utilization of these services.

Spectrum of Services

People in communities across Southwestern Ontario will be given access to a broad range of community services depending upon their needs and the improvements in health which can be demonstrated. A spectrum of community services will be provided which includes health promotion and disease prevention, treatment and rehabilitation services in such areas as community mental health, home support, day care and transportation (particularly in rural areas). Although, community services will be developed for all segments of the population, major emphasis will be placed on long-term care in conjunction with the Provincial Government's initiative to redirect services to the elderly and physically disabled.

Sample Spectrum of Services


REHABILITATION
Developmental Services
Acute Illness Recovery
Vocational Services
Group Homes
Counselling
Out-Patient Therapy
Professional Home Health
Continuing Care
Day Care
Professional Home Health
Home Support
HEALTH PROMOTION AND DISEASE PREVENTION
Health Enhancement
Fitness Programs
Stress Management Programs
Occupational Health Programs
Risk Avoidance
Public Health Education
Dietary Programs
Alcohol and Drug Use Education
Self-Diagnostic Training
Screening Programs
Risk Reduction
Early Identification
IMPROVED HEALTH
TREATMENT
Assessment Services
Out-Patient Treatments
Specialized Care
Access to Institutional Care
Hospitals
Physician Offices/ Clinics
Emergency Services

Cost Effectiveness

The enhancement of community services will be undertaken with consideration to the viability of both existing and new services. On-going consideration will be given to identifying the most effective mode of service delivery and in particular to the relative costs of community services compared with institutionally-based care. Community settings will be the norm for lower levels of service intensity, while high intensity services will be provided in institutional settings. The relative costs and benefits of institutionally-based care and community services will be evaluated in order to shift services between these two modes as appropriate. In addition, opportunities to reduce the fragmentation of service providers and improve the cost effectiveness of existing services will be implemented.

> *"We are not an "add on" service to hospital care but a "substitution" for hospital care."*
>
> Huron County Home Care Program
> Commission Public Consultation Process
> September and October 1991

Research and Evaluation

On-going research into and evaluation of community services will be undertaken to ensure that they are enhanced in a cost effective manner which contributes to improved health.

The Regional and Area Health Management Boards will support the development of an improved data base for community services, the establishment of standard measures of performance, and research into alternate modes of service delivery and evaluation methodologies which are based on measuring the health outcomes from service provision.

Increased Resources

In order to develop the appropriate programs and infrastructure in each community, additional financial resources will be allocated to community services from other areas within the health care system. As recommended by the Premier's Council on Health Strategy in its report "Towards Health Outcomes", the existing share of health care funding devoted to community services will be doubled by the year 2000/01.

The Southwestern Ontario Health Management Board will have the overall responsibility for ensuring that the resources allocated to community services are spent effectively. It will provide each Area Board with an envelope of funds from within the total envelope of funding for the Region. The planning of expanded community services will take place at the Area Board and community level.

Health Professional Resources

Initiatives will be undertaken to develop the necessary health professional resources and, in particular, physicians to provide increased community services. Human resource needs will be identified in each Area and addressed on a systematic basis throughout the Region. Consideration will be given to providing financial and other incentives for health professionals to practice in community settings. The universities and community colleges in the Region will be encouraged to work with community agencies in developing educational programs which include community service training and experience as an integral part of professional education. Health professionals will be offered an understanding of the entire spectrum of community services and their role in the health care system.

> *"It would be wise to change the emphasis of the OHIP funding scheme to support care in the home for situations ranging from routine house calls to palliative care."*
>
> Wharncliffe Family Doctors
> Commission Public Consultation Process
> October to November 1990

The Shift in Emphasis to Outpatient Services

Community hospitals, together with family physicians in their office settings, provide most of the health care services in Southwestern Ontario. Acute care hospitals are the focal point for the delivery of many services in the health care system.

The London teaching hospitals, in addition to providing secondary care also provide tertiary care and highly specialized quarternary services which require a high degree of medical expertise and sophisticated equipment which is found in only a few similar settings throughout the Province.

Over the past several years, in response to policy directions from the Ministry of health, hospitals have been shifting the emphasis in the delivery of services from an inpatient to an outpatient basis. This change has allowed many patients to remain at home while they are receiving diagnostic treatment, rehabilitation and life-support services.

Today, acute care hospitals play a significant role in the provision of outpatient and community outreach services. This role complements their on-going and essential role in the provision of acute care services to patients who must be treated within the hospital setting.

Reduction of Acute Care Patient Days Per 1000 Population

Acute care hospital beds represent the single most expensive resource in the health system and the most intensive and intrusive method of health care delivery. Southwestern Ontario has consistently had a higher rate of acute care institutionalization than the Province of Ontario as a whole. Between 1983/84 and 1988/89, the total number of patient days spent by residents of Southwestern Ontario in hospitals while receiving acute care services was, on average, 10 percent higher than for people in the Province of Ontario as a whole.

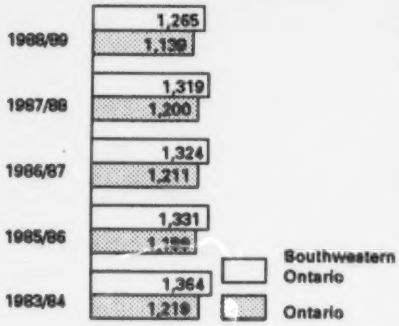
Hospitals in the Region and throughout the Province, have been successful in reducing the use of hospital beds for the treatment of illness. Over the past five years, the average number of patient days spent in hospital per 1000 population has decreased by 1.5 percent per year in Southwestern Ontario and by 1.4 percent throughout Ontario. This reduction has been achieved primarily through the increased use of outpatient service delivery and reduced lengths of stay. If these trends continue, by the year 2001, Southwestern Ontario will be experiencing about 1,055 acute care patient-days per 1000 population compared with 968 in the Province as a whole.

These projections indicate that a significant reduction in the use of inpatient hospital services is occurring over time. However, if the Region is to be successful in achieving its long-term goal of improved health within the financial constraints imposed by the economic realities within Ontario, further reductions in the rate of utilization are required.

At present, there are some 5,477 acute care hospital beds in operation throughout Southwestern Ontario. This figure represents 4.2 acute care beds for every one thousand people in the hospital referral population for the Region. Assuming that these beds were used, on average, 82 percent of the time as at present, the existing number of acute care hospital beds in the Region has the capacity to provide an overall average of 1,175 patient days of acute care services per one thousand population.

Trends in hospital utilization in other jurisdictions in Ontario, such as the Regions of Durham, Peel and York, in other provinces such as Manitoba and in other countries show a lower rate of utilization of acute care hospital beds than in Southwestern Ontario. The number of acute care patient days per 1,000 population required to meet health needs in these jurisdictions ranges between 750 and 1,000. These jurisdictions have been successful in reducing the use of high cost acute care beds through the increased substitution of other, less expensive modes of treatment such as ambulatory care and community-based services, further reductions in average length of stay, and increased efforts dedicated to health promotion and disease prevention. These changes have been accomplished without adverse impacts on the health status of the affected populations.

Number of Acute Care Patient Days Spent in Hospital Per 1000 Referral Population



Source: Ministry of Health

"Currently, the Province is utilizing hospital services at the rate of 1,200 patient days per 1,000 population while the U.S. uses approximately 700 patient days per 1,000 population and is moving towards achieving 600 patient days per 1,000 population. Given the severe economic imperatives facing us, we too have to move in this direction."

Hotel Dieu of St. Joseph Hospital, Windsor
Commission Public Consultation Process
October to November 1990

The number of acute care patient days per 1,000 people required for the Region depends upon the needs of the population in each Area and the extent to which these needs can be met through outpatient or community services. Based on the experience of other jurisdictions, and the previous success in reducing the rate of hospitalization in Southwestern Ontario over the past several years, the following overall targets are considered to be reasonable and achievable over the next ten years:

Patient Days Per 1,000 Referral Population	Existing 1991	Target 2001
Major Urban Centres		
Essex	1,251	900
Middlesex	1,064	900
Other less Urbanized Areas	1,269	950

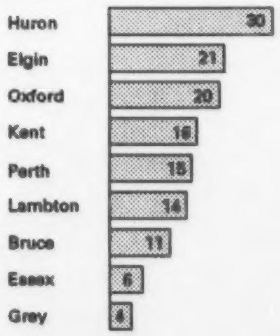
The higher targets for the less urbanized and rural areas reflect the need to provide relatively more hospital services on an inpatient basis since it is usually more difficult to provide outpatient services in these settings. These targets will provide a standard to be achieved by the hospitals in each area. The detailed application of this target may produce some slight variations from this norm due to local needs and circumstances.

Target Referral Population Rates

In addition to providing highly specialized services to some people who live outside Southwestern Ontario, the Health Sciences Complex provides a significant amount of secondary and tertiary hospital inpatient services to residents who live in the Region in counties outside of Middlesex. For example, in 1988/89, the proportion of patients served out-of-county by the London teaching hospitals ranged from a high of 30 percent from Huron County to a low of 4 percent from Grey County.

This pattern of patient referrals can be explained in many ways including such factors as the lack of availability of services on a local basis, physician referral practices, and patients who seek services near

Percentage of Resident Population Referred to London Hospitals by County in 1988/89



Source: Ministry of Health

their location of employment. Given the capabilities of the Health Sciences Complex, particularly with respect to tertiary care, the delivery of hospital services in London to people who live outside the County of Middlesex is in keeping with its role as a regional resource. However, in many cases these out-of-town patients are receiving secondary care services which could be provided closer to home if the capabilities existed to provide them.

The experience of other jurisdictions also supports the notion that more hospital secondary care services could be provided outside of London. While no hard and fast rules exist, it is reasonable to expect that, on average, no more than 13 percent of the total needs of people who reside outside of London should be delivered by the Health Sciences Complex, or by another hospital outside the Region.

"We strongly support the shift to local communities of appropriate primary and secondary care services currently provided in the tertiary care centres."

District Health Councils of Southwestern Ontario
Commission Public Consultation Process
September and October 1991

A target percentage of resident population from outside Middlesex referred to the London teaching hospitals of 13 percent will be established. Achievement of this target will require the establishment of increased capability to provide secondary services among certain community hospitals in the Region. The detailed application of this overall target and the development of the increased capability to provide secondary acute care services at the area and community levels will be guided by the Regional Health Sciences Management Board and the Area Health Management Boards based on local needs and circumstances. In order for this shift in secondary care to occur, both the communities involved and the Health Sciences Complex must be active partners in identifying needs and supporting the development of local capabilities.

Hospital Acute Care Bed Targets

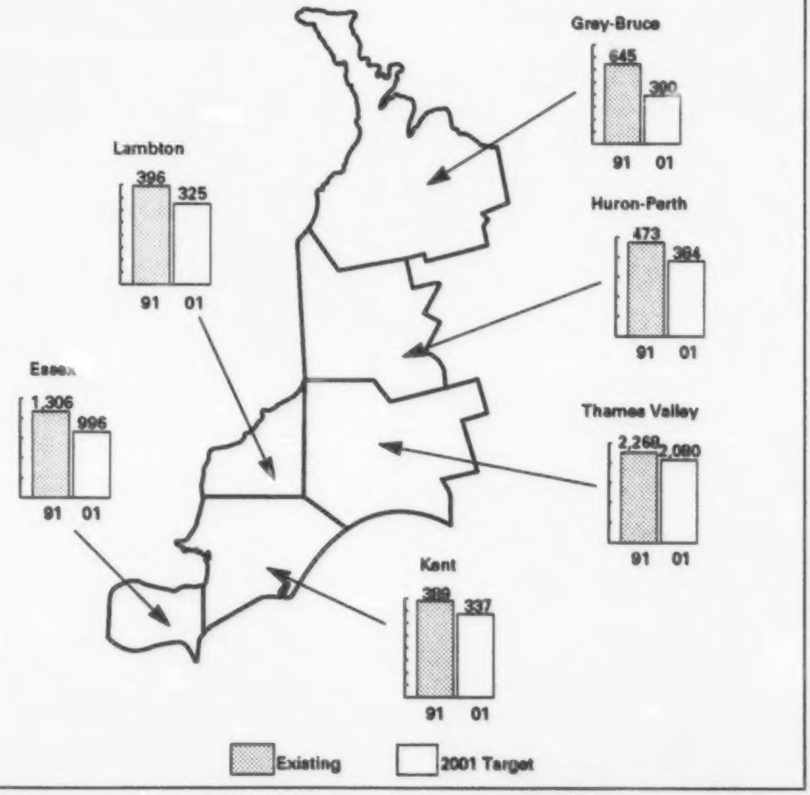
Over the next ten years, the need for hospital beds will be reduced through the implementation of the targets for the number of acute care patient days per 1,000 population and the referral population rate and as a greater proportion of acute care is provided through outpatient and community-based services.

However, with the transfer of some secondary care from London to the local areas, there will also be a redistribution of hospital beds within the Region. This rebalancing of secondary care between the London teaching hospitals and community hospitals will result in economies to the health care system overall.

Applying the target ratios for patient days per 1,000 population and referral population to the population projections, and taking into account the estimated impacts of the aging population on the need for acute care services, results in projected acute care hospital bed requirements of 4,512 for the year 2001. The impact of implementing these targets will vary by area, depending upon the total number of beds required.

> *"It is our belief that an overall 18% reduction of acute care beds (for Elgin) is too conservative. A 20% reduction is feasible and, in our view, necessary."*
>
> St. Thomas-Elgin General Hospital
> Commission Public Consultation Process
> September and October 1991

Acute Care Hospital Beds by Area


Grey-Bruce
645
390
91 01
Lambton
396
325
91 01
Huron-Perth
473
384
91 01
Essex
1,306
996
91 01
Thames Valley
2,260
2,080
91 01
Kent
399
337
91 01
Existing
2001 Target

The achievement of these targets for reducing the number of beds will represent a first phase in a systematic approach to rationalizing acute care hospital services across the Region. It is anticipated that further rationalizations will follow into the next century.

A Changing Role for the Health Sciences Complex

Existing Role

The role and responsibilities of the Health Sciences Complex comprise three broad categories:

- patient services;
- education of health professionals, and
- research and scholarship.

The role of the Health Sciences Complex also extends beyond the Region in areas such as education and training, research and the provision of certain quaternary services. These aspects of its role, compared to the other hospitals in Southwestern Ontario, need to be recognized and supported by the Regional Health Sciences Management Board within the context of the governance and management of the health care system in the Region. At the same time, based on input from the public consultations, increased attention by the Health Sciences Complex to meeting the needs of the Region is required.

Potential Role

It is important that the Health Sciences Complex expand its role in supporting tertiary patient care, health professional education, and health research throughout and beyond the Region. In order to support the goal of improved health for the people of Southwestern Ontario, the Health Sciences Complex will be encouraged to enhance its role through:

- changes in the composition of its individual hospital boards to make them more representative of the entire community (the Region) they serve;
- recognition of a social contract with the population of Southwestern Ontario;
- commitment to developing educational programs which are more broadly based, including the education of all types of

health professionals in both institutional and community settings in all areas of the Region, and

- commitment to developing an information centre for managing the health of Southwestern Ontario's population and for developing teaching and research priorities.

In addition, the Health Sciences Complex will be requested to consider several changes in its role which will support improvements to the health care system in Southwestern Ontario including:

- an expanded role in community health epidemiology;
- continued rationalization of inpatient beds and ambulatory services with the objective of increasing the capability of selected community hospitals to provide secondary care while reducing the overall utilization of acute care hospital beds in the Region;
- increased support for the education of health professionals through closer linkages to health service providers, particularly in rural, underserviced areas, and
- leadership and coordination of Region-wide medical and non-medical research efforts in identified priority areas, including the evaluation of outcomes from new initiatives in health promotion and disease prevention and community services.

> *"Greater interaction with community hospitals and other community health care agencies will become a focus as University Hospital attempts to reduce the length of stay to its inpatients and integrate them back into their own communities more rapidly."*
>
> University Hospital, London
> Commission Public Consultation Process
> October to November 1990

Joint Strategic Plan

The three teaching hospitals in London and the University of Western Ontario have initiated a joint strategic planning effort. The objectives of this effort are to rationalize further clinical services, to evaluate alternate health care delivery models involving linkages with other health service providers in the Region, to address how high quality, efficient and cost-effective care can best be provided and to foster advanced academic achievement which contributes to patient care. The major capital development plans of each hospital will be modified on the basis of the results from this exercise.

The Health Sciences Complex will be supported in its joint strategic planning efforts and encouraged by the Regional Health Sciences Management Board to establish an overall strategic plan which identifies the combined patient services, educational and research needs of the three hospitals and the University of Western Ontario. This strategic plan will serve as the basis for the establishment of a single, long-term capital plan for facilities development which takes into account bed requirements, the needs for ambulatory care facilities and other capacity questions as well as the broader needs of the Region.

Collaborative Governance

The three individual hospitals in the Health Sciences Complex operate with independent boards of governors and management structures. The joint strategic planning effort initiated by these hospitals and the University of Western Ontario is an important stage in developing a closer relationship among the major participants in the Health Sciences Complex which will lead to more integration of services and increased cost effectiveness.

The London teaching hospitals and the health science faculties and schools of the University of Western Ontario will be encouraged to consider further means of collaboration with respect to governance and management. Such efforts will enhance the ability of the Health Sciences Complex to implement the integrated strategic plan for development. In so doing, the future role of the Health Sciences Complex within the health care system throughout Southwestern Ontario will be enhanced and the opportunities for dealing with the on-going funding pressures through improved effectiveness and efficiency maximized.

The Need for Reform

Long-term care services include a wide array of services which are provided for the elderly and people with physical disabilities or prolonged illness. These services are provided in peoples' homes (including such services as nursing care, personal care, meals on wheels, for example), in the community (such as transportation, adult day programs and Alzheimer programs), and in institutional settings (such as residential and extended care in nursing homes and homes-for-the-aged and chronic care in hospitals).

Over the past several years, succeeding provincial governments, recipients, and providers of long term care services have become concerned with the present system of long term care delivery in this Province. The present system is characterized by higher institutionalization rates than most other Provinces, inconsistencies in funding between the Ministries of Health and Community and Social Services, a significant backlog of medically stable patients in acute care hospital beds who are awaiting transfer to a long term care institutional setting and an underdeveloped services network in most communities.

Throughout the public consultations, there was a strong desire expressed by individuals in Southwestern Ontario for a greater say in how long-term care services are delivered and a greater voice in selecting the setting for receiving these services. Service providers at several public meetings also urged that the health system be changed in order to allow people in need of long term care services to lead more independent lives at home or in non-institutional settings such as in seniors apartments or rest and retirement homes.

Based on the experience of many recipients and previous studies, major changes are required in order to meet the demands of a growing population of elderly and physically disabled persons and to provide a more cost effective system which emphasizes community-based and in-home services.

Long-Term Care in Southwestern Ontario

The delivery of long term care is a major component of the health care system in Southwestern Ontario. In 1989/90, there were more than twelve thousand long term care beds in hospitals, nursing homes and homes for-the-aged in the Region. The estimated costs of operating these beds were in the order of $400 to $450 million. Community and home-based long term care services add many more millions of dollars in overall cost.

There are many excellent and well motivated institutional and community-based service providers in Southwestern Ontario who are providing high quality services. However, there is no integrated or consistent approach to planning and providing the spectrum of long term care services which is required to support individuals at reasonable cost in the most appropriate setting. As a result, there are gaps in services and the people who require assistance often have difficulty in knowing what services are available or how to access them. Only within the past few years have service providers in the community begun to initiate shared service arrangements.

Representatives of the public and service providers at the public consultations identified gaps in community services, such as transportation and affordable housing with limited health services support, and in health professional resources, such as psychogeriatricians, in rural areas such as Bruce County.

While the growth rate in the elderly population will be less significant in Southwestern Ontario than for Ontario as a whole (1.3 percent versus 2.7 percent), the increasing number of people who require on-going support in their homes or in institutional settings will place a burden on the health care system in Southwestern Ontario. Between 1991 and 2001, the number of people in the Region over the age of 65 will increase by 24,500 which is one quarter of the total projected population increase of 98,000 for the Region. The highest increases will be Lambton County, followed by Essex and Middlesex Counties.

Long-Term Care Community Services

The provision of improved and expanded long-term care and support services for the elderly and physically disabled through a system which shifts the emphasis from institutional to community-based care and in-home support is the goal of the present Provincial Government. This goal will be adopted as part of the plan for the health system in Southwestern Ontario.

In keeping with the Provincial Government's plans for the "Redirection of Long-Term Care and Support Services in Ontario" and as part of the broader initiative to enhance community services in the Southwest Region, support systems for delivering long-term care in the community and in people's homes will be enhanced over the next ten years, and a significant proportion of long-term care services which are currently provided in institutional settings will be provided in non-institutional settings.

The final recommendations from the Provincial Government's review of long-term care will be enacted through a coordinated, Region-wide effort involving the new Boards, service providers, and the recipients of services and their families. With special new funding previously announced by the Provincial Government, a wide range of services such as community outreach and day care services, emergency services and increased in-home support services including transportation, safety devices, and home maintenance, will be considered for development in each area based on need.

Long-term care institutions will be encouraged to play a more significant role in providing community-based and in-home services through collaborative efforts with community-based providers.

The feasibility of further increases in alternative housing such as apartments and rest and retirement homes which provide some health care and support services, will also be assessed. More information and education on the long term care system will be made available to service recipients and their families, paid service providers and volunteers.

> *"The redirection of long-term care services will allow us to shift the emphasis from over-reliance on facility service to the development of creative community-based services."*
>
> **Source:** Ministry of Community and Social Services

Additional hospital beds for shorter-term rehabilitation from surgery and medical problems will be designated from within the overall hospital bed targets for Southwestern Ontario. More respite beds will be provided in long-term care settings to accommodate service recipients for short periods of time, thereby providing relief to family members.

Long-Term Care Institutional Services

Long-Term Care Beds

There is a total of 12,499 long-term care beds in hospitals, nursing homes, and homes for-the-aged throughout Southwestern Ontario. These beds include 2,023 chronic care hospital beds and 2,271 residential care and 8,090 extended care beds in nursing homes and homes for-the-aged. In total, there are 169 long-term care beds per thousand people over the age of 75 years in the Region.

A standard of 140 beds per thousand people over the age of 75 years is presently in use in the Province of Manitoba and was recently adopted by the Windsor-Essex Long-Term Care Services Planning Committee. It is reasonable to expect that this standard can be applied to the Southwest Region. It will, therefore, form the basis for managing long-term care beds in the Region to the year 2001.

On this basis, a total of 13,626 long-term care beds will be required in Southwestern Ontario in the year 2001. These beds will be located in hospitals, nursing homes, homes for-the-aged, and other newly-defined long-term facilities.

The achievement of this target, together with upgrading and replacement of obsolete facilities, will require substantial changes in existing facilities as well as significant enhancements in home support and community services in most areas of the Region. These enhancements will need to be funded from within the envelope of funds allocated to the Region.

"There will always be those who require a high level of care and a range of specialized services where community-based supports will not be adequate or appropriate. The need for chronic care institutions will continue, even in the presence of a fully-developed system of community-based care."

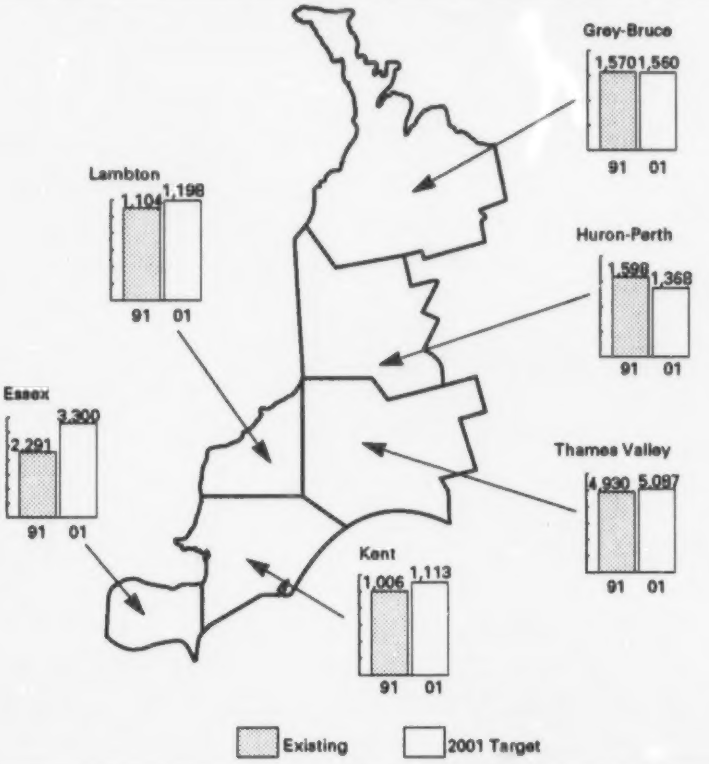
Parkwood Hospital, London
Commission Public Consultation Process
October to November 1990

"In view of the projected growth in the number of older elderly, it is clear that the issue of how many beds are needed cannot be resolved without addressing the fragmentation, the maldistribution and inconsistencies in how and for whom the beds and community care are used."

**Source: Professor Evelyn Shapiro
Faculty of Medicine
University of Manitoba**

Within the overall target bed ratios, the needs and availability of long term care beds will be balanced on an area-by-area basis across the Region. Consistent with changes in the funding of long term care beds which are established through the Provincial Government's redirection of long-term care, the existing proportion of beds for residential, extended and chronic care (non-specialty) will also be revised according to the needs of the population in the Region. An important part of the rationalization process will be the reduction of the backlog of patients in acute care hospital beds who are awaiting placement in long term care settings.

Long-Term Care Beds by Area


Grey-Bruce
1,570
1,560
91
01
Lambton
1,104
1,198
91
01
Huron-Perth
1,598
1,368
91
01
Essex
2,291
3,300
91
01
Thames Valley
4,930
5,087
91
01
Kent
1,006
1,113
91
01
Existing
2001 Target

Specialty-Chronic Care Beds

Long-term care beds are intended to meet the needs of medically stable people. In addition to these beds, there is the need to provide acute care hospital services for chronically ill patients who are medically unstable. Experience with other jurisdictions shows that an average of 175 "specialty-chronic care" beds per million population is a realistic standard for Southwestern Ontario.

Applying this standard to the projected population for the Region produces a total projected need of 254 specialty-chronic care beds in the year 2001. The balance of the existing chronic care beds in hospitals will be reallocated to become general long-term care beds. The redesignation of more than 85 percent of existing chronic care beds will have a significant impact on hospitals in all parts of the Region and will lead to a redefinition in the roles of some hospitals which have all or a significant portion of their beds designated as chronic care.

THE PLAN: TOWARDS BETTER MANAGEMENT OF OUR HEALTH

Summary

Human resources are perhaps the most important of all in the delivery of health services. However, there is no overall or comprehensive human resources planning system for Southwestern Ontario or for the Province as a whole. Meeting the health needs of the people of Southwestern Ontario in a cost effective manner will depend largely upon the ability of the health care system to provide the appropriate human resources in the right place at the right time. Implementation of the plan for 2001 can only proceed as the capacity to manage and deploy health human resources with the Region is established.

The planning and management of human resources will be changed from the existing fragmented approach to a more systematic and multi-disciplinary basis aimed at the health needs of individual communities. The development and implementation of a human resources plan for Southwestern Ontario will focus on the identification of specific underserviced and overserviced areas with respect to professional, managerial, technical and non-professional resources.

Once the specific human resources needs have been identified, they will be met through an overall approach to planning at the Regional and Area level which involves the encouragement of human resources migration by means of substitution, reorganization of services, and financial incentives. The Regional and Area Health Management Boards will be responsible for the difficult task of implementing these improvements.

The education of health professionals will be enhanced through:

- encouragement of cooperative efforts between colleges and universities;
- decentralization of educational programs to community hospitals and other health agencies, and
- establishment of educational programs which support the broad concept of health and its improvement.

THE PLAN: TOWARDS BETTER MANAGEMENT OF OUR HEALTH

Summary

The human resources plan for managing physician services will include:

- measures to manage the number, location and types of physicians to meet the health needs of the Region;
- alternate funding arrangements which are designed to support the overall management of patient care and reduce the rate of growth in the total costs of physician services, and
- mechanisms for monitoring service utilization.

Introduction

Effective human resources planning is essential to ensure that appropriately trained and experienced staff are available and deployed throughout the health system to provide high quality health services. Individuals must have assurance that the services they receive are appropriate to their needs and circumstances.

There is no overall or comprehensive human resources plan or planning process for the Southwestern Ontario Region. Human resources planning has tended to be reactive and short-term in nature. This situation is typical for the health system in Ontario and in other jurisdictions in Canada. Historically, human resources have been planned and managed through measures which are aimed primarily at the health professional and technical groups on an individual basis rather than from a comprehensive perspective which takes into consideration the needs for all categories of health personnel. Compensation and funding systems are oriented to the individual profession or service provider rather than to the continuum of needs of individual communities. There are some exceptions. In a limited number of cases in the Region, some groups and institutions have responded well to local needs through a combination of initiatives including the provision of financial and other incentives for professionals in short supply.

The Availability of Human Resources Throughout Southwestern Ontario

On a Region-wide basis, human resources are not always deployed or utilized in such a manner as to meet the needs of individual communities. Throughout the public consultations, members of the public and representatives of service providers expressed concerns over shortages in professional human resources in their areas and the negative impacts that these deficiencies cause in accessibility to health care.

There are numerous types or categories of human resources which serve in the health system. Each plays a particular role in providing the services which are required to meet the needs of the people in the Region. By necessity, the following discussion focuses on a few of the larger groups. However, in no way, should this be taken to detract from the importance of the many other groups of health professionals and non-professionals who serve in the system.

Physicians

There are more than forty different categories of general and specialty physicians who provide services to the population of Southwestern Ontario. Each plays an important role in the health system. Some physicians, such as family practitioners, are generalists who provide primary care in their offices, in hospitals and in other community-based agencies. Others are specialists and sub-specialists who are usually called upon to provide secondary and/or tertiary services respectively after the hospital emergency department or the family doctor has identified a specific health problem.

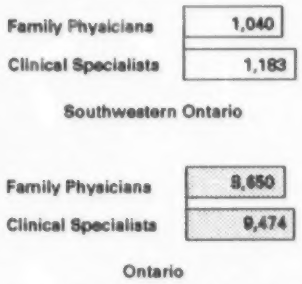
Over the past several years, the growth in the supply of physicians has exceeded the population growth in Ontario and the Southwest Region. Between 1981 and 1986, the total number of physicians in Ontario increased to 19,000, a growth of 19 percent, compared to an increase in population of only 5 percent. In Southwestern Ontario, the number of physicians increased by almost 14 percent to 2,400 against a population growth of one percent over this same period.

Family Physicians

Overall, the Southwestern Ontario Region appears to have an adequate number of family practitioners. In 1989, the ratio of population per active family physician in Southwestern Ontario was 1,277 compared with 1,109 for the entire Province.

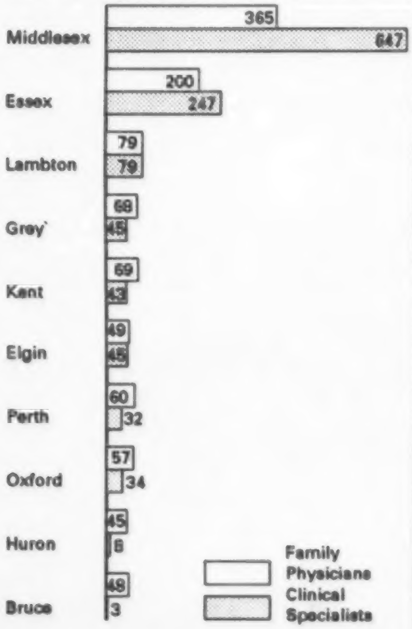
Within the Southwest Region there was a significant range in the ratio of population to active family physician, from a high of 1,234 in Bruce County to a low of 956 in Middlesex. In addition, based on input from the public consultations, there are shortages of family practitioners for hospital emergency room coverage in some rural

Active Physicians in 1989



Source: Ontario Physician Manpower Data Centre

Active Physicians by County in 1989



Source: Ontario Physician Manpower Data Centre areas where the demands on physicians' time are heavy, particularly in terms of providing on-call services. In these cases, the limited number of physicians available and the resulting stressful lifestyle can be a major deterrent to attracting and retaining physicians. These problems are particularly evident where there does not appear to have been any affirmative action taken to attract such professionals.

Other communities have undertaken special initiatives to attract family physicians. For example, to introduce students to rural practice, one hospital has established, through the Auxiliary, a residence for attracting medical interns and residents for specific terms under the supervision of local physicians. Other local initiatives include the construction of a medical services building adjacent to the local hospital. The success of these and other communities in attracting family practitioners through innovative arrangements underscores the opportunity to address existing shortages on a more consistent basis.

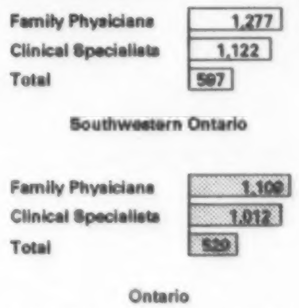
Clinical Specialists

In 1989, the ratio of population per active clinical specialist in Southwestern Ontario was 1,122 compared with 1,012 for the entire Province.

The 1989 data also shows a wide variation in the number of people per clinical specialist throughout the Southwest Region. The specialist population is centered in the major urban centres and particularly in the Health Sciences Complex in London where there is a critical mass of peers and where the major educational and research efforts in the Southwestern Region are undertaken. For specialists in general fields such as general surgery and internal medicine, this clustering of physicians is not as evident.

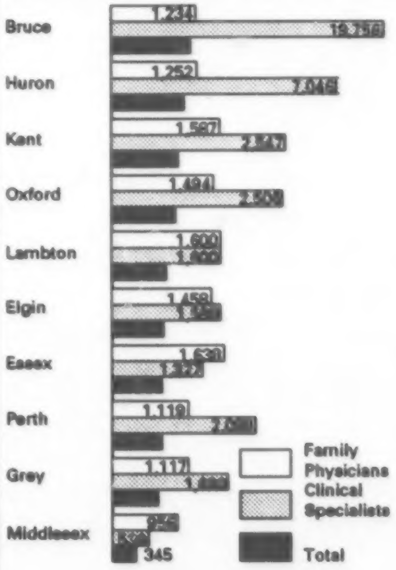
There are a number of underserviced areas with respect to the provision of services by physician specialists. Shortages of general surgeons, geriatric psychiatrists, obstetricians and anesthetists were identified during the public consultations. Although the trend data on the supply of specialists is somewhat incomplete and conflicting,

Population per Active Physician in 1989



Source: Ontario Physician Manpower Data Centre

Population per Active Physician in 1989



Source: Ontario Physician Manpower Data Centre it appears that the number of general surgeons and obstetricians in Ontario did not increase significantly between 1981 and 1988. The number of general surgeons may even have declined slightly over this period.

Despite problems with the availability of specialty services in rural areas, some communities have successfully attracted specialists through the use of physicians on a part-time basis or the establishment of specialist groups which are shared among several communities within reasonable travelling distance from one another. However, the issue of critical mass requirements remains a significant constraint to the availability of specialists in the smaller and more remote communities in Southwestern Ontario. Other constraints include difficulties in providing continued physician training and competitive incomes compared with the urban centres in the Region.

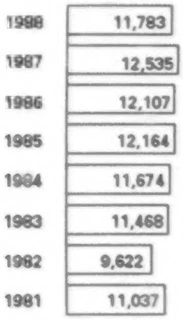
More aggressive and flexible approaches will be needed to attract clinical specialists to underserviced areas, including such measures as professional linkages, on-going training and transitional income guarantees.

Registered Nurses

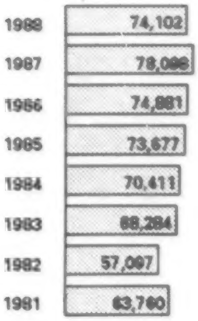
The number of registered nurses employed in Ontario in general and in the Southwest Region in particular, has remained relatively constant over the past five years. In 1989, there were 11,800 registered nurses employed in Southwestern Ontario, which was a slight reduction from 1985. Based on these limited data, and the input received from the public consultations, it would appear that there is an adequate supply of registered nurses in the urban areas of Southwestern Ontario. However, some rural areas may be experiencing shortages. For example, in 1986, there were vacancies in most isolated jurisdictions in the Province.

The recent contractual agreement with the Ontario Nurses' Association, coupled with on-going funding restraints by the Provincial Government, will likely mean that fewer registered nurses will be employed over the next ten years as some present non-nursing

Number of Registered Nurses Employed



Southwestern Ontario



Ontario

Source: College of Nurses of Ontario

functions are transferred to other categories of staff. As a result, with some redistribution of resources to rural areas, there will be an adequate supply of registered nurses in Southwestern Ontario in the year 2001. The key to attracting registered nurses to underserviced areas will be to ensure that consistent clinical education is provided throughout the Region.

The Canadian Nurses' Association has resolved that, by the year 2000, all registered nurses will require at least a baccalaureate degree in nursing to enter into practice. If this recommendation is implemented, a concerted effort will need to be undertaken to provide locally-available education to enable nurses to upgrade their status. Universities and community colleges in the Region will need to work collaboratively in adapting their nursing programs accordingly.

Registered Nursing Assistants

The number of registered nursing assistants employed in Ontario has increased by some 8 percent between 1981 and 1988 while the total for Southwestern Ontario has shown a slightly higher percentage increase over the same period.

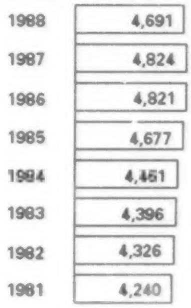
With the recent change in compensation for experienced registered nurses, the requirements for registered nursing assistants should increase. However, this increase may be mitigated somewhat if health providers create expanding roles for health care aides who have an intermediate level of training.

Physiotherapists And Occupational Therapists

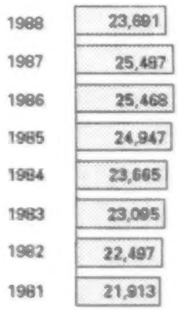
In 1988, there were approximately 2,700 physiotherapists in Ontario including 375 in the Southwestern Region. At the same time, the vacancy rate was 12 percent and 13 percent respectively.

The total number of occupational therapists in Ontario was 1,400 in 1981, including some 185 in the Southwestern Region. The vacancy rate for occupational therapists was 12 percent and 12.5 percent respectively.

Number of Registered Nurses Assistants Employed



Southwestern Ontario



Ontario

Source: College of Nurses of Ontario

The number of physiotherapists increased by some 56 percent between 1981 and 1988, as the aging population and the increasing emphasis on rehabilitation and return to active lifestyles in the community began to place increasing demands on the health system for rehabilitation staff. At the same time, there has been relatively less use of para-professionals in these categories compared with the physician and nursing groups. With the continued growth in demand for rehabilitation services, there will likely need to be greater use of para-professionals in the future if the needs of the population are to be met.

Homecare/Homemakers

There is little data on the supply and demand for homecare workers and homemakers in the Province and the Southwestern Region. In 1989, there were approximately 14,000 homemakers employed in formal homecare programs provided by the commercial and not-for-profit sectors throughout Ontario.

Due to the rapid expansion of homemaker services in the Province and to relatively low hourly rates of pay, there have been significant shortages in staff over the past several years. This situation was partly alleviated in September 1990 when pay rates were increased substantially. The demand for these categories of staff will continue to increase with the aging population and the continued focus on devolution of services from institutions to the community.

Introduction

The Southwestern Ontario Health Management Board will be responsible for planning and managing the human resources requirements to meet the long-term health goals and objectives for the Region. It will work in collaboration with the Regional Health Sciences Management Board, the six Area Health Management Boards, service providers, and educational institutions in determining and fulfilling these requirements. Human resources planning will be based on meeting the identified health needs of the population at the community level, rather than the existing vertically-oriented approaches to human resources planning which focus on individual professions and service providers. The Regional and Area Boards will use the strategies of substitution, reorganization of services and financial incentives to encourage the development of human resources to meet community needs.

A major area of focus will be on improving the supply of human resources and the availability of health services in the underserviced areas throughout the Region. With respect to rural areas, the critical mass requirements will be considered in determining the requirements for health professionals.

Substitution

Until recently, the delivery of services by the health professionals in the Province of Ontario has been governed by the Health Disciplines Act which sets out the qualifications required to practice as a member of a particular health profession. Over the past several years, succeeding provincial governments have been reviewing and revising the basic premises which govern the health professions in Ontario. The new Regulated Health Professions Act sets out specific scopes of practice for the health professions and identifies the specific acts which may be performed by each profession. In so doing, the new legislation identifies those acts which, while once the exclusive domain of a particular profession, can be performed by members of another profession or by para-professionals.

Needs-Based Human Resources Management

From a human resources management perspective, this legislation will enable the greater use of substitution – the use of alternate professionals or para-professionals to perform certain treatments or procedures where the cost effectiveness or accessibility of services can be enhanced. Two widely noted examples of substitution are the use of midwives to perform some of the traditional functions of obstetricians and a greater role for nurses in patient care through the performance of certain treatments, procedures and patient education, which have previously been carried out only by physicians.

Substitution has the potential to improve cost effectiveness and quality of care, as well as increase job satisfaction for the professionals involved. With appropriate training and education, health professionals can adapt to new scopes of practice which permit more effective and rewarding use of their time and expertise with patients.

In its proper form, substitution can benefit both the individual and the health professional. From the individual's perspective, substitution can provide certain services which would otherwise not be available due to a shortage in health professionals. The use of nurse practitioners, coupled with periodic services from physicians, is a prime example of how substitution can improve the availability of health services. From the point of view of the professional, substitution can free up time for other functions.

Another form of substitution is the potential for increasing the role of the recipients of health services in providing for their own health care needs and for the needs of people close to them. Individuals often play a significant role in meeting their on-going health needs. Self-examination techniques, physiotherapy and the administration of insulin and other drugs are common examples. The potential exists, through increased emphasis and training, to train recipients to perform certain procedures which are presently carried out by health care workers within the primary care system.

The Regional and Area Health Management Boards will establish an overall strategy and plan for substitution in the Southwestern Region. The techniques considered for this plan will include:

- encouragement by the Regional and Area Boards for health care professionals to establish multi-disciplinary professional group practices involving professionals from various disciplines;
- education for physicians, nurses, and other groups with respect to new scopes of professional practice;
- expanded roles for registered nurses in the provision of patient care;
- expanded roles for family physicians;
- expanded roles for registered nursing assistants and other categories of non-professional nursing staff;
- expanded roles for other para-professionals such as rehabilitation assistants and homemakers;
- encouragement of professional groups and the Provincial Government to modify existing payment mechanisms, and
- training the public to assume a greater role in self-care and in certain self-examination techniques as well as the use of alternate services, such as doctors offices or community-based services instead of hospital emergency departments.

Reorganization of Services

The traditional organization of service providers according to the nature of the service or the type of professional has led to a health system which is convenient for the provider but which may not be in the best interests of the individual. In the future, service providers will be encouraged to become more consumer-focused in their mandates, structures and human resources. Shifts in cultural attitudes toward a needs-based focus, involvement of the recipients of care in decision making and a more effective use of human resources skills at all levels will also be encouraged.

Management Skills

The development of improved general management skills in such areas as public relations, marketing, finance, communications and team-building will be provided in support of the effective management of consumer-oriented service organizations. This training will be designed to assist service provider managers in seeking a higher degree of participation from individual recipients of care in decision-making processes.

Human Resources Data Base

In order to provide service providers with more complete, accurate and timely information with respect to the supply and demand for human resources, a comprehensive data base for Southwestern Ontario will be established and maintained by the Regional Health Management Board.

Physician Financial Incentives

Financial incentives will be established in order to attract family physicians to underserviced areas throughout the Region. The Regional and Area Health Management Boards will encourage local service providers to ensure that family practitioners have the opportunity to establish scopes of practice which are financially attractive and professionally rewarding. In return, these physicians will be responsible for meeting some of the less rewarding, but necessary needs of the community.

> *"It is difficult to attract physicians to the smaller cities. Approximately 14 percent of our medical staff is nearing retirement age. We could face a significant loss of service to our community before replacements could be brought in."*
>
> St. Joseph's Hospital, Chatham
> Commission Public Consultation Process
> October to November 1990

Decentralization

At present, human resources education is largely effective at the core professional level and within most of the major institutions. However, in future, substantially more initial and continuing education of future health professionals will need to be conducted in the institutional and community settings in which they will practice. The Southwestern Ontario Health Management Board, through its Educational Advisory Group, will encourage the decentralization of education where appropriate. As the shift in emphasis in the plan is implemented, more education will take place in community settings.

Integration of Educational Programs

In its final report on a review of the mandate of Ontario's Colleges submitted to the Ministry of Colleges and Universities in 1990, ("Vision 2000: Quality and Opportunity"), the Ontario Council of Regents for Colleges of Applied Arts and Technology recommended the facilitation of the movement of students between the college and university sectors. The University of Western Ontario and Fanshawe College have recently signed an agreement to formally establish a liaison committee that would identify areas of potential cooperation between the two institutions with respect to nursing education. Cooperative efforts between colleges and universities and hospitals and other health agencies in planning and promoting an integrated system of education for health professionals will be encouraged.

Health Professionals

In conjunction with Regional initiatives in health promotion and disease prevention, increased emphasis will be placed on the education of professionals and other health care workers outside their normal disciplines. Universities and community colleges will be encouraged to provide educational programs which include such concepts as:

- health promotion and disease prevention;

- health economics;
- environmental awareness;
- health management;
- bioethics;
- health care outcomes, and
- multi-disciplinary care delivery.

Such generalist training will also enable increased substitution as well as facilitate cross-referrals of patients within multi-disciplinary teams.

Management of Physician Services

Introduction

As the primary decision-makers with respect to the provision of health care to individuals, and having the power to determine whether or not many services are made available, physicians will continue to play a major role in the health care system in Southwestern Ontario. In view of their important role in how the health system is utilized and the significant percentage of total health care spending devoted to physician services, the need and costs for physicians need to be effectively managed.

The number of physicians practising in Ontario has been increasing at a much faster rate than the needs of the population would suggest is required. In Southwestern Ontario, there appear to be more physicians entering into the health system each year than are required to meet the needs of the health care system. At the same time, there are needs for increases in the number of physicians in particular areas throughout the Region.

As an independent health entity with a specific envelope of funding for the delivery of all health services in Southwestern Ontario, the Southwestern Ontario Health Management Board must be equipped to meet the needs for physician services by having an effective means to manage the number of physicians and the costs of physician services. Without such control, continued growth in the number and costs of physicians have the capacity to erode other health services which are funded from within the same funding envelope and prevent the successful achievement of the plan for 2001.

Over the past several years, coincident with the growth in the number of physicians, a contributing factor in the increasing costs of physician services has been an increase in utilization – the volume and types of services provided per patient. It is difficult to determine the health benefits from the increased utilization of services. Both the patient who requests the service and the physician who provides it have a direct impact on the utilization of the health care system. Any approach to managing and controlling the utilization of health services needs to take both roles into consideration.

Management of Physician Services

The human resources plan for managing physician services will address the important issues of managing the number, location, and types of physicians required to meet the health needs of the Region, alternate funding and service arrangements, and mechanisms for monitoring the utilization of physician services. While the Regional and Area Boards and service providers will have the primary responsibility for managing physician services, physicians themselves will also be encouraged to participate in all aspects of this process. In addition, the Regional bodies will require legislative authority to manage physician resources within Southwestern Ontario.

Needs-Based Physician Resource Management

Following a 1989 operational review of twenty-two hospitals with recurring operating deficits, in an attempt to provide better control over the growth in programs and services, the Ministry of Health implemented a policy requiring hospitals to manage their physician requirements within their approved budgets. Before hospitals can add new physician specialists to their medical staff, a formal impact analysis must be undertaken which identifies the service needs being met and the incremental costs of providing the additional services. Through the Independent Health Facilities Act, the Ministry of Health has also initiated controls over the entry of specialists into community settings.

The Southwestern Ontario Health Management Board, together with the Regional Health Sciences Management Board and the Area Boards, will adjust service provider budgets to reflect the need for specific increases or decreases in the number and type of physicians and the attendant physician costs by local area throughout the Region. Where necessary and appropriate, financial incentives will be built into service provider budgets to encourage the migration of particular types of physicians to underserviced areas.

As previously stated, a comprehensive data base of the supply versus need for all human resources including physicians will be developed. This data base will be used to assist service providers with the management of physician needs. Shortages will be met by attracting physicians from areas within the Region with a surplus of the same type of resource or from beyond the Region. In addition, the "underserviced area" provisions in the May 1991 agreement between the Provincial Government and the Ontario Medical Association will be employed. Physician resources which are beyond the needs of the Region will not be given access to the health system in Southwestern Ontario. The Regional Health Management Board will work with university medical schools in identifying the appropriate numbers and types of physicians in the future.

Alternate Funding Arrangements

In order to reduce the growth in the total costs of physician services and to encourage physicians to relocate in underserviced areas, the Ministry of Health has promoted different methods for compensating physicians other than a fee-for-service basis. These include incentives for practising in Northern Ontario, physician salaries through Community Health Centres, capitation approaches through Health Service Organizations and global budgeting for academic physician staff in health science centres. While the future of such agreements is subject to change due to the recent Ontario Medical Association agreement with the Provincial Government, many physicians are supportive of these types of arrangements as viable alternatives to fee-for-service. In order to support the role of physicians in multi-disciplinary approaches to care delivery, to encourage physician migration, and to control the growth in the total costs of physician services, communities and service providers in Southwestern Ontario will be encouraged to adopt innovative, non-traditional ways of organizing and funding their health services.

Utilization of Physician Services

The utilization of physicians in the health care system is an issue which has been under examination by the Provincial Government and the Ontario Medical Association since the early 1980s. To date, there have been no significant results from this process in terms of documenting the impacts of increased utilization on the quality of health care, nor have any major initiatives been established to monitor or control utilization patterns.

While utilization has proven to be a difficult topic, the central role of physicians in delivering and prescribing health services underscores the importance of taking some steps to address this issue. There are two basic levels on which utilization will be managed - general physician practice patterns or norms, and the appropriate use of health system resources.

An independent Utilization Review Board will be established with the mandate to review the use of existing or future practice guidelines for physicians and other health professionals and to review or audit specific instances which appear to involve the inappropriate utilization of services. This Board will be composed of physician and non-physician representatives and act as an independent arm on behalf of the Southwestern Ontario Health Management Board.

Educational programs which support the appropriate utilization of health care services will be developed and provided for the public and for all health professionals.

THE PLAN: TOWARDS BETTER MANAGEMENT OF OUR HEALTH

Summary

In the future, the development of health facilities will be undertaken in a manner which is fundamentally different than in the past. Capital investment will be viewed as a strategy for improving the effectiveness and efficiency of the health system while meeting the goals for improved health in Southwestern Ontario. Capital dollars will be utilized as a resource for reducing operating costs through such means as rationalizing existing services or improving the efficiency of existing facilities and for establishing new, cost-effective services which meet identified needs.

A capital planning and decision-making process, which is based on return on investment principles, will be implemented. All individual capital projects will be required to reduce the operating costs of the health system by an amount which is at least sufficient to offset the cost of capital. Incentives will be provided for projects demonstrating the greatest improvements in efficiency and cost effectiveness. Individual service providers, together with the Regional and Area Health Management Boards, will be accountable for making capital decisions and for achieving the stated benefits of each project.

Substantial capital development of existing hospital facilities over the next ten years will be essential in order to replace obsolete buildings and systems, to reflect the shift from in-patient to ambulatory services, to support the enhancement of secondary care services in certain communities and to reduce inpatient hospital services. Along with the development of hospital facilities will be the need to establish new, free-standing ambulatory care and community-based health facilities.

Facilities development will be overseen by the Southwestern Ontario Health Management Board, the Regional Health Sciences Management Board and the Area Health Management Boards, based upon the specific health care needs in their respective areas of jurisdiction. The plan for facilities development will differ significantly from the existing proposed capital spending plans of individual hospitals in the Region.

THE PLAN:
TOWARDS BETTER MANAGEMENT OF OUR HEALTH

Summary

Future capital spending in Southwestern Ontario will be based on an integrated, ten-year plan for facilities development. This plan will include the following five strategies:

- implementation of the hospital bed targets for acute and chronic care to the year 2001;
- optimum utilization of health facilities;
- rationalization of health services among institutional and community-based service providers, particularly in areas served by two or more hospitals;
- reduction of operating costs through increased productivity, and
- the provision of minimum acceptable standards of accommodation for patient care and access for disabled persons.

The plan for developing health facilities in the Region over the next ten years will be based on the following framework of initiatives:

	Total Capital Expenditure ($ millions)
Enhancement of Viable Community Hospitals	100
Rationalization and Upgrading of Services	150
Redevelopment of The Health Sciences Complex	175
Upgrading of Engineering and Building Systems	50
Enhancement of Long-Term Care Facilities	75
Total Capital Expenditure	550

This plan does not include any capital expenditures which may be required for the development of new, alternative facilities to traditional long-term care institutional services, the establishment of free-standing ambulatory care centres or the redevelopment of psychiatric hospital facilities. The total capital expenditure over the next ten years may vary from the estimate of $550 million, depending upon the extent to which capital spending can be justified on the basis of need and return on investment.

Past Capital Spending

Introduction

Facilities play an important, but subsidiary role in shaping health services. The amount and quality of space and equipment can be limiting factors to the range and volume of services which are provided in any health facility. However, there are many other aspects in the planning, management and delivery of health services which play an equal, if not more important role. In many respects facilities are influential, rather than determining factors in the system.

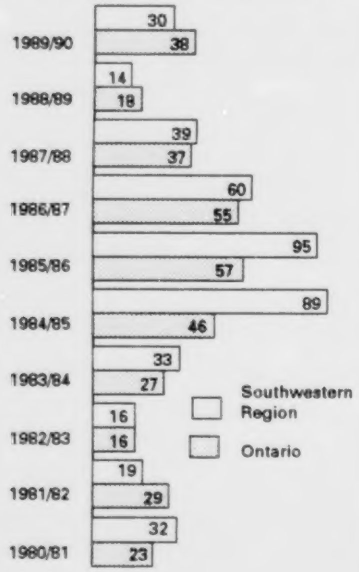
Facilities, by their nature, are capital intensive to develop and costly to maintain. How, where, and in what manner health facilities are developed in the future will determine, to a large degree, the nature, quality, costs, and efficiency of health services in the Region. The nature, location, and extent of facilities should be solely related to the needs of the population served and to the dictates of cost effectiveness, service efficiency and critical mass necessary for the optimum deployment of health professionals.

Definition of Capital Expenditure

Capital expenditure includes spending on new or renovated buildings for the purposes of expanding or improving programs and services or upgrading technical deficiencies in the building fabric or systems. Capital costs include installations and equipment procured through a construction contract; professional and technical services associated with construction, such as architectural and engineering fees, site surveys and geotechnical investigations; and the cost of securing regulatory approvals such as building permits or certification of medical gas systems. The funding of capital projects is typically shared between the Ministry of Health and the community on a two-thirds to one-third basis respectively.

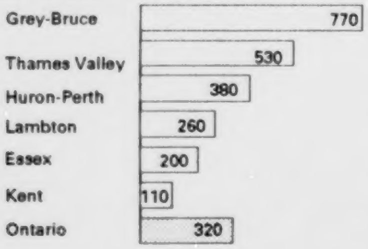
Capital costs exclude expenditures associated with moveable furniture, furnishings and equipment, including medical and nursing equipment, which typically account for between 15 and 20 per cent of the cost of a construction project and which are usually funded

Comparison of Hospital Capital Spending Per Capita Referral Population in 1990



Sources: Public Accounts of Ontario
Ministry of Treasury & Economics

Total Hospital Capital Spending Per Capita Referral Population in 1990



Sources: Public Accounts of Ontario
Ministry of Treasury & Economics

separately. Capital cost estimates are approximate only, due to variations in the assumptions and estimating procedures of individual hospitals.

Previous Spending Patterns

Over the past ten years, average capital spending by hospitals in Southwestern Ontario has amounted to the equivalent of $56 million per year or approximately 18 percent of the total capital spending by all hospitals in Ontario. On a per capita basis, when compared with the respective 1991 referral populations, the ten-year investment in hospital facilities in Southwestern Ontario was $410 per capita compared to $320 per capita for the Province as a whole.

Over this same period, capital spending per capita has varied widely by Area within the Region. When compared with the 1991 referral population by Area, total capital spending over the past ten years ranged from a high of $770 per capita in Grey-Bruce to a low of $110 in Kent versus an average of $320 for the Province.

Condition of Existing Facilities

Hospital facilities in the Region vary widely in terms of their age, condition and suitability to the services provided. Some buildings which are currently in use date from the 1890s. Twenty hospitals have at least some space which dates from 1950 or earlier. The 1960s were active decades in hospital construction when many smaller community facilities were established and most hospitals were expanded.

Hospitals devote a significant effort to everyday housekeeping of their facilities, and endeavor to maintain even the oldest buildings at an acceptable standard. Even so, a significant part of the Region's stock is functionally and technically obsolete.

Certain facility limitations are common in small community hospitals of less than 100 beds. Emergency and ambulatory care facilities are frequently inadequate to meet today's needs and standards. In many cases, there is little patient privacy and there is a lack of suitable space for diagnostic facilities. Imaging facilities and laboratories are often well equipped but inadequately housed.

Many smaller hospitals operate facilities which include 20 to 40-year-old inpatient accommodation space. While fundamentally sound, several deficiencies are common, including a lack of bathing and washroom space, little or no wheelchair-access, and an inadequate number of single and double patient rooms. Many hospitals with a small bed complement have had difficulties in modifying their inpatient accommodation to meet bed requirements. Nursing units are often uneconomically sized, and house various types of acute and long term patients with different needs.

The deficiencies found in larger hospitals with more than 100 beds are more diverse and specific to the institution concerned. They stem from age, and a mismatch between their facilities and their changing role and practices. With larger bed complements and more space, they have had more flexibility to adjust to changes than smaller hospitals. Nevertheless, there are a few large hospitals with serious facilities problems; others have facilities which are barely adequate.

Proposed Capital Projects of Hospitals

Overview

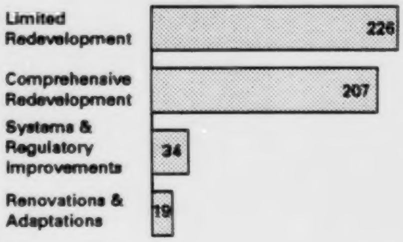
At present, the forty-six hospitals in Southwestern Ontario are proposing to undertake facilities expansion and redevelopment projects which represent more than $486 million in capital spending over the next several years. These capital projects fall into four major categories:

- replacement or comprehensive redevelopments including new hospitals and programs of extension and upgrading which will result in a substantially new hospital;
- limited redevelopment involving extensions, increases in size, or renovations which affect significant parts of an institution but fall short of comprehensive renewal;
- renovation and adaptation projects which involve the reuse of existing facilities without any increase in size; and,
- systems and regulatory proposals affecting building systems, or components of the building fabric only, with no changes in hospital programs or services.

The proposals for facilities development, measured by their value, fall primarily into the first two categories. These projects would add substantially to the total stock of buildings, and have the potential to increase future operating costs. For the most part, the proposed spending would add or improve existing spaces.

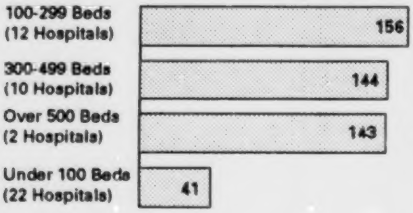
The amount of capital investment planned for systems and regulatory upgrading is relatively small. This may be because these developments have been pre-empted by more comprehensive projects. It might also reflect the success of recent programs such as the Fire Code Retrofit and recent improvements which have been made to fire and life safety systems, medical gases and patient communications systems.

Hospital Capital Spending Proposals by Type of Project ($ Millions)

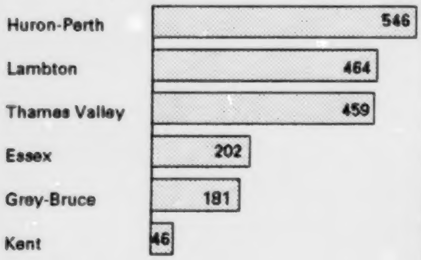


Proposed Capital Projects of Hospitals

Hospital Capital Spending Proposals by Size of Hospital ($ Millions)



Hospital Capital Spending Proposals by Area ($ Per Capita Referral Population)



Proposed Spending by Hospital Size

The proposed capital spending by size of hospital shows a relatively even distribution on hospitals over 100 beds. On a per hospital basis, the greatest amount of spending is proposed for the two largest hospitals in the Region (Victoria Hospital and St. Joseph's Health Centre in London). The proposed capital spending for hospitals under 100 beds is modest by comparison.

Proposed Spending by Area

When considered on a per capita basis, there is a wide variation in proposed capital spending as a ratio of the existing referral population by Area. The proposed spending varies by more than tenfold between Areas from a high of $546 per capita in Huron-Perth to a low of $46 in Kent. Proposed spending is significantly higher for Huron-Perth, Lambton and Thames Valley than for the remaining three Areas.

Comparison of Past and Proposed Spending

The total spending implied by the currently planned projects is similar to the amount consumed in the last ten years. The distribution across the region is also similar. Thames Valley as a whole, and the London Teaching hospitals in particular, account for the greatest share of planned expenditures. These proposed capital spending plans of hospitals must be modified significantly if the other long term goals for improving the health system in Southwestern Ontario are to be accomplished.

Other Considerations

A number of potential but very significant projects have not been identified, because the hospitals in question have not developed proposals in sufficient detail to describe them. In addition, there are other proposed projects which need to be reassessed. For example, spending projected for Kent County would not be sufficient to accomplish all of the physical remedial work which is necessary.

Proposed Capital Projects of Hospitals

Few existing proposals offer the potential for significant operating cost savings in return for the capital expended. Most would ensure appropriate surroundings for given activities, or accommodate new activity, or an increased volume of activity.

Major Facilities Development Issues

Introduction

A significant capital investment in hospitals throughout the Region is required in order to replace obsolete and inadequate facilities. At the same time, there are major opportunities for improving the effectiveness and efficiency of the existing system through the rationalization of hospital services and facilities. Any significant delays in making necessary capital investment decisions will create higher operating costs for repairs and breakdowns, service interruptions and greater risk to patients and staff. Such delays will ultimately lead to higher capital costs in the future as facilities deteriorate further before any action is taken. There are several major facilities development issues which, due to their size and potential impact on the effectiveness and efficiency of services, need to be addressed specifically in any future capital spending plan for Southwestern Ontario.

London Hospitals

St. Joseph's Health Centre is primarily a community hospital but supports three acute tertiary programs in perinatology, endocrinology and metabolism, and gastroenterology/GI surgery. It is the oldest hospital in London with portions of its physical plant dating back to the 1880's. The greater part of the physical stock is approximately 30 to 37 years old.

Although the quality of care provided is good, the buildings of St. Joseph's Health Centre are inadequate – in terms of space, layout, environment, and building systems technology. The chronic lack of space has led to haphazard departmental relationships and main circulation routes which interfere with patient care and clinical activities.

The Health Centre has acquired a large property immediately to the north of the existing site and is planning a long range redevelopment. The first phase, valued at approximately $15 million is intended to relieve the most critical pressures on the buildings, namely:

- outpatient clinic space;
- additional imaging and day procedures area;
- clinical laboratory space;
- expanded perinatology, and,
- education space.

In addition, St. Joseph's Health Centre is planning to spend close to $5 million in capital on upgrading programs in the short term.

In spite of this capital investment, many deficiencies and inadequacies will remain. Continued redevelopment will be necessary because the existing buildings have outlived their usefulness for the delivery of contemporary health care.

University Hospital is a free-standing tertiary care teaching facility, built 19 years ago. With the exception of the Robarts Research Institute and MRI Building (both built in 1986) plus the Multi-Organ Transplant Unit (built in 1987), relatively little capital has been invested in upgrading or expanding space for patient care programs since the original construction.

In order to provide additional space in keeping with the original design concept of horizontally related activities (inpatient beds, clinics, and research), the Hospital plans to construct an extension to the front of the building. The extension will emphasize outpatient activity, a medical mall, and a hostel in support of tertiary health services. Overall, this project is estimated to cost $58 million.

Victoria Hospital is located on two separate sites, the result of interrupting a 1980 plan for complete consolidation on a new site. South Street's buildings date from 1904, with the main Hospital, housing surgical suite and diagnostic imaging, being between 38 and 50 years old. A younger wing, 24 years old, accommodates the critical care and trauma unit.

Victoria Hospital provides tertiary care for Southwestern Ontario and primary and secondary services for London and surrounding areas. The completion of the consolidation of services on Westminster Campus and the abandonment of the South Street site is the central issue with respect to the effective and efficient delivery of patient care over the long term. The Hospital functions with difficulty in a disjointed operation which produces inefficiencies and detracts from the provision of quality care. To compound these problems, the facilities at South Street are inadequate.

The Hospital has considered upgrading South Street and rationalizing services across two sites. The capital cost estimate for such a scheme is approximately $95 million for South Street alone. This investment would not alleviate all the limitations of the physical structures of South Street, nor would it alleviate the problem of operating on two sites. The other alternative is to complete the consolidation on Westminster Campus, which the Hospital estimates would cost approximately $123 million.

In addition to their individual facilities needs and issues, the London teaching hospitals are in the process of examining opportunities for further rationalization of clinical services between institutions.

Windsor Hospitals

In terms of its buildings, the **Metropolitan General Hospital** is one of the best in the Region. It has been well maintained and regularly upgraded. It has certain needs related to functional organization and space availability, but these could be met at relatively modest cost.

Hotel Dieu-St. Joseph's Hospital is the largest hospital in Windsor and is accommodated in buildings whose ages range from 30 to 50 years old. The facilities are nearing the end of their useful life.

Windsor Western Hospital Centre, based on the Prince Road site, has a Master Plan, a well-developed program of capital spending extending some years in to the future and construction is underway. The site and structure of the Hospital are ideally suited to accommodate incremental expansion. The first major component planned to construction, following an infrastructure upgrading project, will be the $40 million long term care facility designed to replace the Riverview Unit.

The Salvation Army Grace Hospital owns facilities of variable quality. Recent additions and renovations housing emergency services, day surgery, rehabilitation, the neonatal nursery and other departments are excellent. Other parts of the Hospital date back to 1941, and many patient services are accommodated in 1954 and 1966 buildings. Throughout the facility there are signs of aging in systems and fabric and functional layout.

"There are unnecessary duplications in Windsor, such as three psychiatric units where there should only be two and four 24-hour emergency departments where, from a community point of view, there should also only be two."

Hotel Dieu of St. Joseph Hospital, Windsor
Commission Public Consultation Process
October to November 1990

Despite some consolidation of services in recent years, there is an unacceptable degree of duplication of services across the City; for example, there are four emergency departments, three inpatient psychiatric programs and three hospital laundries. There is also excess operating room capacity among the hospitals.

The hospitals recognize that this situation cannot persist and, together with the Essex County District Health Council, are conducting a joint planning process to identify opportunities for service rationalization. This process may lead to a reduction in the number of acute care hospitals in Windsor.

If they were to be maintained, three out of the four Windsor hospitals would require significant investment over the next decade. The consolidation of one or more hospitals would also require a major capital investment as the remaining hospitals accommodate displaced activities. However, such an investment would have major benefits including the potential to significantly increase the efficiency of care delivery and reduce the overall hospital operating costs within the City of Windsor.

Chatham and Sarnia Hospitals

The Cities of Chatham and Sarnia are medium-sized centres with two acute care hospitals. There is an opportunity to improve efficiency and cost effectiveness through the rationalization of hospital services and facilities in these two cities.

In Sarnia, a substantial amount of capital has already been spent at **St. Joseph's Hospital** while the **Sarnia General Hospital** has identified redevelopment needs of over $40 million.

The **Public General Hospital** in Chatham has sections which need to be replaced in the short term and needs to be progressively upgraded over the next decade. **St. Joseph's Hospital**, by contrast, has generally excellent facilities with some capacity to absorb further activity. The two hospitals have begun to consider how their services can be integrated.

Long Term Care Hospitals

At least $93 million of the proposed capital spending in Southwestern Ontario is earmarked for long term care facilities. The bulk of these funds are requested for the replacement of the Riverview Unit at the **Windsor Western Hospital Centre** and the replacement of **St. Mary's Hospital**, London. There is little doubt that, in both cases, the existing facility is inadequate and needs to be replaced. However, redefinition of the type of patient who will be accommodated in hospital-based, specialty chronic care will necessitate a review of these proposals before proceeding.

The bed requirements for chronic care in acute care hospital settings throughout the Region will also be reduced to house only medically unstable or specialty chronic care patients. This decrease will have significant implications for the longer term role and future development of many hospitals.

Capital Planning and Approval Process

Under the new system of governance, individual service providers will retain their current responsibilities for planning and managing the development of their facilities. However, the authority for project approval will be transferred to the Region from Queen's Park. The process for planning and approving capital projects will also be significantly different than in the past in two other major respects. First, in addition to being consistent with the facilities development strategies in the plan, capital projects will need to contribute to the achievement of the long-term goals for improved health in Southwestern Ontario. Secondly, all projects will be required to generate improved efficiency and reduced operating costs which at least offset the cost of capital. Incentives will be provided for projects where the greatest improvements in efficiency and cost effectiveness through the rationalization of services can be demonstrated.

Facilities Development Strategies

The development of health facilities in the Region will be planned and carried out according to the following objectives:

- implementation of the Plan for the health system in Southwestern Ontario to the year 2001. The inpatient utilization targets for acute care of 900 and 950 patient days per 1,000 population in urban and rural areas respectively and the application of the new definition of hospital-based specialty chronic care will reduce the number of acute care and chronic care beds required in acute care hospitals. At the same time, hospitals may take on new or expanded roles in the provision of outpatient, ambulatory, and community-based services. Significant capital spending will be undertaken to support the rationalization of the health system and to adapt acute care hospitals to perform new roles effectively and efficiently in a new operational environment. Where needed, new, free-standing ambulatory care and community-based health facilities will also be established;

- the achievement of optimum levels of utilization of hospital services as measured in comparison with other jurisdictions in Canada. Facilities will be developed in such a manner as to establish utilization rates which are among the most effective and efficient in Canada;
- rationalization of services, particularly in those areas served by two or more hospitals. While the ultimate form of "rational" services in these centres will be determined by the service providers, together with the Regional and Area Health Management Boards, the potential alternatives and the existing conditions of the building stock in these centres indicate that a significant commitment of capital will be required over the next decade;
- reduction of operating costs. With the increasing costs of health care and the difficulties in supporting these increases through public funds, the health system will have to become more productive and cost effective through the investment of capital in hospital facilities, and
- the provision of minimum acceptable standards of accommodation throughout the Region. Many submissions during the public consultation process expressed concerns over the lack of appropriate facilities.

Capital Spending Initiatives

The capital spending plans for the Region will be defined in detail by the Regional and Area Health Management Boards in concert with the capital projects put forward by individual service providers and based on priorities established within each Area. According to an independent assessment of existing hospital needs and subject to meeting the requirements of the new capital planning and approval process, the overall plan will include capital spending of some $550 million over the next decade. This amount is approximately the same amount of spending which has taken place over the past ten years.

In addition to the capital expenditures which are now committed or anticipated, the need for further facilities development projects will be identified over the next ten years. Funding for these new projects will be provided through the reallocation of funds from other projects within the global amount of $550 million, based on priority of need.

The ten-year plan for capital spending in Southwestern Ontario will include five major areas or initiatives.

Enhancement of Viable Community Hospitals

Many community hospitals have functional and technical deficiencies and are unattractive and inconvenient for staff and patients. A total of $100 million will be spent over the next ten years in upgrading viable facilities in order to strengthen the delivery of primary and secondary care throughout the Region. This initiative will include:

- the establishment of a referral hospital facility for the Huron-Perth Area;
- upgrades to community hospitals in smaller communities which have only one hospital, and
- the correction of defects in basic accommodation, such as wheelchair-accessible washrooms, bathing and nursing facilities.

Rationalization and Upgrading of Services

As part of the process for achieving the hospital bed targets for the year 2001, and for improving the efficiency of the health system, there are several opportunities to improve the effectiveness and efficiency of the hospital services in large and medium-sized centres in the Region, through the consolidation or rationalization of hospital services.

The sum of $150 million will be spent on the following capital development initiatives:

- rationalization of acute care services in the Windsor hospitals;
- rationalization of services and facilities in Chatham and Sarnia, and
- transfers of inpatient facilities to other hospitals.

Rationalization alternatives will consider the consolidation and closure of facilities.

Redevelopment of the Health Sciences Complex

The three teaching hospitals which comprise the Health Sciences Complex each have important facility capital development needs and priorities. A specific mandate of the Comprehensive Health System Planning Commission was to identify the facility development requirements for the Health Sciences Complex.

The establishment of a second campus for Victoria Hospital has created a less than optimum framework for maximizing the efficiency of health services in London. Based on the relative quality of the existing accommodation in the three hospitals and the number of patients and staff affected, the consolidation of all Victoria Hospital operations on the Westminster Campus is the most pressing facilities issue and will be given the highest priority. In keeping with the long-term goals of enhancing community services and rationalizing the use of institutional services throughout the Region, the consolidation will be based upon a downsizing of in-patient operations from 750 to 600 beds and the enhancement of ambulatory care services on the Westminster Campus only. In addition to the creation of new facilities, the existing Westminster Tower will be utilized for inpatient services, and the London Psychiatric Institute facility, when vacated, will be considered for alternate uses. Further capital spending will be undertaken to address the facility needs at St. Joseph's Health Centre and University Hospital.

Projects in the teaching hospitals will proceed when a framework has been established by the Teaching Hospitals' Council and when the specific bed reduction targets have been established. The London

Teaching Hospitals' Council will be encouraged to rationalize services among the three teaching hospitals as soon as possible in order to assist in generating the operating cost savings which would permit the consolidation of Victoria Hospital to proceed.

A total of $175 million will be earmarked for the redevelopment of the Health Sciences Complex. This figure includes approximately $110 million for the consolidation of Victoria Hospital.

Upgrading of Hospital Engineering Systems and Building Elements

This initiative will include projects identified previously by the hospitals and will involve the expenditure of $50 million.

Enhancement of Long Term Care Facilities

A total of $75 million in capital spending will be designated to address long term care facility needs including:

- replacement of the Riverview Unit, Windsor Western Hospital Centre;
- replacement of St. Mary's Hospital, London, and
- improvements to other facilities in the Region as required.

THE PLAN:
TOWARDS BETTER MANAGEMENT OF OUR HEALTH

Summary

The plan for improving the management of the health of the residents of Southwestern Ontario sets out major new initiatives for improving health and the health system. These new directions will necessarily involve the investment of additional resources in several areas of the health care system, particularly in the development of community services, the enhancement of health promotion and disease prevention, and the redevelopment of acceptable physical facilities.

Over the next decade, the financial environment for health care will be more difficult than in the past. The ability of the Provincial Government to finance the health care system is diminishing over time. It is understood that the share of total government spending on health care will not be increased beyond its present level of 33 percent of the total Provincial budget. As a result, in today's dollars, Government of Ontario funding for health care in Ontario is expected to increase at an average rate of only 3.0 percent per year to 2000/01 (the estimated annual rate of growth in Gross Provincial Product), compared with an actual increase of 5.5 percent between 1980/81 and 1990/91.

Given this reality, implementation of the plan will need to be accomplished largely through the reallocation or redistribution of existing health system financial resources from one category of spending to another, and through improvements in effectiveness and efficiency, rather than by means of any new monies.

In total, ignoring inflation, it is anticipated that the Provincial allocation for health care spending in Southwestern Ontario will increase from an estimated $2.2 billion in 1990/91 to $2.9 billion in the year 2000/01. Including inflation, this number is expected to be $3.7 billion.

In order to achieve the strategic objectives for improving health included in the plan, and to reflect the changing needs of the population, the allocation of the total envelope for health care spending in the Region by major category of expense will need to be modified gradually over the next ten years. The share of spending devoted to community services, health promotion and disease prevention, and to long-term care will be increased significantly. The share of spending on hospitals will decrease while the proportion of spending devoted to physician services and other OHIP payments will remain at the existing level.

"Enhanced programs for Health Promotion and Disease Prevention are supported as is the thrust toward community-based services. Acute care hospital services must be viewed as a scarce resource to be used only when absolutely necessary."

Hotel Dieu of St. Joseph Hospital, Windsor
Commission Public Consultation Process
September to October 1991

Health Care Spending in Ontario

As described previously, the share of total annual Provincial Government expenditures devoted to health care has increased from 28 percent in 1979/80 to a projected level of 33 percent in 1990/91. The Provincial Government has expressed concern that, if the growth in health spending were to continue at the same rate, expenditures on other high priorities, such as education, social services and economic development, would be reduced significantly. Not only would this diminish other government initiatives directly, reduced expenditures in these areas would have an adverse impact on the health of the population. Based on these considerations, the Provincial Government has declared that the proportion of total government spending on health care will not grow in the foreseeable future.

In its 1991/92 budget, the Provincial Government announced its intention to reduce the growth in health care spending through "the more prudent management of the health care system in Ontario". The 1991/92 budget calls for an increase in total health care spending of 5.2 percent, ignoring inflation. This compares with an average increase of 5.5 percent in health care spending over the previous ten years.

"The system isn't being managed and it needs to be managed. It needs to be run better."

Source: Bob Rae, Premier of Ontario

It is the Provincial Government's intention to "ensure that the resources dedicated to health care are spent more effectively, efficiently, and with greater economy, while maintaining the high quality of our current system". The Government also recognizes the need to increase health care spending as the needs and size of the population increase and to address some important challenges of health care, among them the aging population, the reduction of major diseases such as cancer, and the impacts of new technology.

The Provincial Government's spending policies are expected to limit any increases in health care spending across the Province. As a result, without inflation, Government of Ontario funding for health care is expected to increase at an average rate of only 3.0 percent per year to 2000/01 (the estimated annual rate of growth in Gross Provincial Product).

"We are probably spending quite enough on health care. The real savings that will enable us to increase programs will come from a critical appraisal of the effectiveness and efficiency of existing service delivery programs."

Department of Physical Medicine and Rehabilitation
University of Western Ontario
Commission Public Consultation Process
October to November 1990

Health Care Spending in Southwestern Ontario

Implementation of the plan will require the financing of new initiatives in several areas. It is clear that the funding for these initiatives will have to be provided through the reallocation of funding from other areas or efficiencies within the health care system rather than from the injection of new funds. Only through a rationalization of existing services and improved effectiveness and efficiency can the long-term goals for improving health be accomplished within the resources available.

In the future, the amount of funding available from year to year for the delivery of health care in Ontario will depend upon specific policies of the Provincial Government. However, for the purposes of estimating the total funding which will be available for the health care system in Southwestern Ontario in the year 2001, it is assumed that, without the effects of inflation, expenditures in the Region will grow by an average of 3.0 percent per year over the next ten years, compared with an average annual growth rate of 5.6 percent between 1983/84 and 1988/89. This means that, ignoring inflation, the total operating expenditures on health care in the Region are expected to increase from an estimated $2.2 billion in 1990/91 to $2.9 billion in the year 2000/2001. With the effects of inflation factored in, the total spending on health care in 2000/2001 is estimated to be $3.7 billion. It is from within this level of funding that the goals for improved health must be accomplished while maintaining or enhancing the quality of care provided by the existing system.

Spending Allocation Targets

Long-Term Spending Allocation Guidelines

Over the next ten years, implementation of the plan will require gradual changes in the relative allocation of health care spending in Southwestern Ontario among the major categories of expenditures. The determination of how and when this reallocation will occur at the Area and individual program and service provider levels will be the responsibility of the Regional and Area Health Management Boards in conjunction with service providers and input from the public. However, it is important to provide an overall framework of long-term spending targets by major category of expenditure which will provide guidance to these bodies.

Growth Rates in Health Care Spending

The redistribution of health care spending by major category required to support the plan will produce the following projected changes in average annual growth rates in expenditures in Southwestern Ontario:

TYPE OF EXPENDITURE	HISTORICAL GROWTH RATE (1983/84 to 1988/89)		FUTURE GROWTH RATE (1990/91 to 2000/01)	
	WITH INFLATION (%)	WITHOUT INFLATION (%)	WITH INFLATION (%)	WITHOUT INFLATION (%)
Community Services	14.3	9.7	12.1	9.4
OHIP Payments	11.9	7.3	5.7	3.0
Ontario Drug Benefits	19.7	15.1	8.4	5.7
Community Hospitals	6.8	2.2	3.2	0.5
Health Sciences Complex	9.2	4.6	5.0	2.3
Long-Term Care Facilities	8.7	4.1	6.8	4.1
Psychiatric Hospitals	6.9	2.3	2.8	0.1
Other Services	10.2	5.6	4.7	2.0
Combined Growth Rate for All Services	10.2	5.6	5.7	3.0

Projected Health Care Spending

The estimated growth rates in health care spending will produce the following projected spending levels in Southwestern Ontario by the year 2000/01:

Type of Expenditure	Estimated Actual Spending (1990/91)	Projected Spending (2000/01)	
		With Inflation	Without Inflation
	($ millions)	($ millions)	($ millions)
Community Services	127.2	409.3	319.1
OHIP Payments	613.1	1,056.8	823.9
Ontario Drug Benefits	116.6	260.5	203.1
Community Hospitals	535.4	718.2	559.9
Health Sciences Complex	377.8	606.5	472.9
Long-Term Care Facilities	241.8	461.4	359.7
Psychiatric Hospitals	77.7	100.5	78.3
Other Services	69.1	107.9	84.1
All Services	2,158.7	3,721.1	2,901.0

Changes in Spending Allocations

Community-Based Services

As described in the plan, a comprehensive system of community-based services will be established. The proportion of health care expenditures allocated to community services (such as Home Care, Local Health Agencies, Community Mental Health, Assistive Devices, and Substance Abuse Programs) will be doubled. As a result of these measures, between 1990/91 and 2000/01, the total share of expenditures on community services will be increased from 5.9 percent to 11.0 percent. Ignoring inflation, the average annual growth rate of expenditures on community services between 1990/91 and 2000/01 will be 9.4 percent.

OHIP Payments

At present, physician services account for most of the total OHIP expenditures across the Province (with Commercial Laboratories, Out-of-Province Payments and Payments to Other Practitioners accounting for the remainder). As part of the plan, measures will be undertaken to reduce public demands for physician services where appropriate and also to manage the number of physicians practising in the Southwest Region. In addition, the Provincial Government, through the Interim Agreement on Economic Arrangements between the Ministry of Health and the Ontario Medical Association, has taken steps to manage the utilization of physician services in the Province.

Through these means, the total share of health care expenditures devoted to OHIP benefits will be held at the current level of 28.4 percent. Without inflation, the average annual growth rate in OHIP payments will decline from 7.3 percent between 1983/84 and 1988/89 to 3.0 percent between 1990/91 and 2000/01.

Ontario Drug Benefit Plan

The Ontario Drug Benefit Plan provides prescription drugs free of charge to Ontario residents over the age of sixty-five and to recipients of social assistance. Over the past ten years, the average annual growth in Ontario Drug Plan costs has been in the order of 19 percent. This high growth rate has been due to three factors:

- increases in the average number of claims per claimant;
- increases in the number of claimants, and
- average price per prescription.

The Ontario Government, in its 1991 Budget, announced that measures will be introduced to reduce the annual growth in Ontario Drug Benefit Plan costs.

In Southwestern Ontario, the rapid growth in spending on prescription drugs for the elderly will be curtailed through initiatives to maintain or reduce the utilization of drugs. As outlined in the plan, cooperative efforts among physicians, pharmacists and the public to reducing the utilization of prescription drugs among the elderly will be introduced and coordinated by the Regional and Area Boards. Through these measures, it is expected that there will be no increase in the average number of claims per claimant.

However, over the period between 1990/91 and 2000/01, increases in the number of elderly claimants and in the average price per prescription are expected to produce an increase in the allocation of health expenditures to the Ontario Drug Benefit Plan from 5.1 percent to 7.0 percent. Without inflation, the average annual growth rate in Ontario Drug Plan costs will decline from 15.1 percent between 1983/84 and 1988/89 to 5.7 percent between 1990/91 and 2000/01.

Community Hospitals

The shift in emphasis in the delivery of appropriate care from institutions to community services will enable the number of community hospital beds throughout the Region to be reduced. In total, community hospitals will operate with 18 percent fewer beds per 1,000 population in the year 2001 than in 1988/89. In addition, a significant proportion of services which are currently performed by community hospitals will be provided through independent health facilities. As a result, between 1990/91 and 2000/01, the allocation of health spending to community hospitals (excluding expenditures on long-term care services) will be reduced from 24.8 percent to 19.3 percent. Over this period, the average annual growth rate in expenditures (without inflation) for community hospitals will be 0.5 percent compared to 2.2 percent between 1983/84 and 1988/89.

Health Sciences Complex

The increased emphasis on community services and the development of increased capability of certain community hospitals to provide secondary care will also reduce the proportion of health care expenditures for patient care on the Health Sciences Complex. This impact will be offset to a larger degree than for community hospitals due to the relatively higher population growth which is expected in the patient catchment area for The Health Sciences Complex. As a result, the share of health care expenditures on teaching hospitals (excluding long-term care expenditures) will be reduced from 17.5 percent in 1990/91 to 16.3 percent in 2000/01. The average annual growth rate in real expenditures for teaching hospitals will decline from 4.6 percent between 1983/84 and 1988/89 to 2.3 percent.

Long Term Care Facilities

In total, there is an estimated need for 1,400 more long-term care beds in the year 2001 to accommodate the institutional needs of the elderly population. This represents an increase of 11.5 percent over the number of existing beds in 1990/91. Under the proposed new provincial system for funding long-term care services by level of care, it is expected that there will be some cost savings in institutional care. Assuming that the Provincial Government's initiative for the redirection of long-term care services is implemented over the planning period, the combined impact of these changes will be an increase in the allocation of health care expenditures to long-term care from 11.2 percent in 1990/91 to 12.4 percent in 2000/01. Ignoring inflation, the average annual growth rate between 1990/91 and 2000/01 will be 4.1 percent, the same as the rate of growth between 1983/84 and 1988/89.

Psychiatric Hospitals

Initiatives will be undertaken to reduce the operating costs of psychiatric hospitals through increased operating efficiencies and the continued transfer of patients to community-based treatment settings. It is estimated that the impact of these measures will be a reduction in the proportion of health care expenditures on psychiatric hospitals from 3.6 percent in 1988/89 to 2.7 percent in 2000/01. Without inflation, the projected average annual growth rate in expenditures on psychiatric hospitals will be 0.1 percent between 1990/91 and 2000/01, compared with 2.3 percent between 1983/84 and 1988/89.

Other Services

Expenditures for the remaining services in the health care system include the following:

- clinical education;
- emergency services;
- cancer treatment and research;
- clinical research;
- operation of the Regional and Area Health Management Boards;
- health resources development, and
- health agencies and special health initiatives.

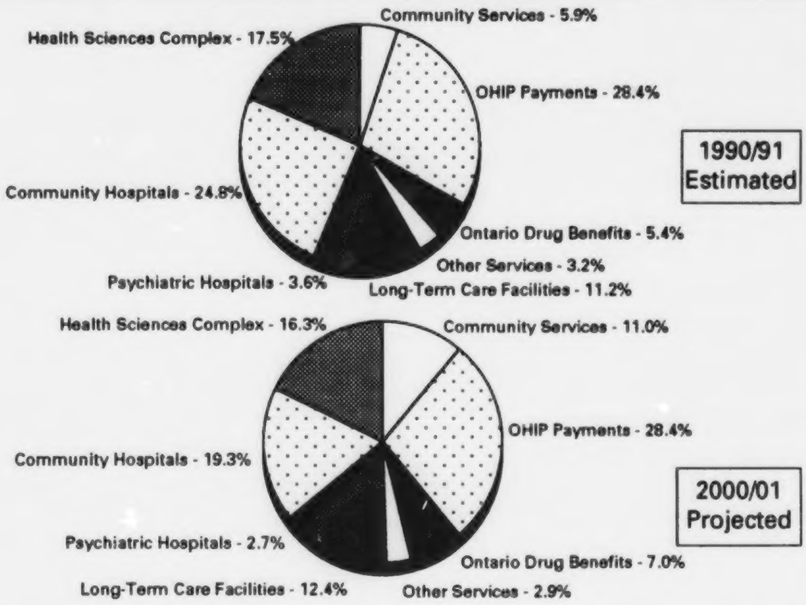
The increased distribution of clinical education of physicians, nurses and other health professionals from the Health Sciences Complex to local sites across the Region will require increased expenditures for accommodating and supervising students. Otherwise, the total spending on other services is not expected to change significantly over the planning period. The total share of health care spending for other services will be 2.9 percent in 2000/2001 compared to 3.2 percent in 1988/89.

Summary of Changes in Spending Allocations

The implementation of the new directions outlined in the plan will produce significant changes in the pattern of health care expenditures in Southwestern Ontario over the next ten years. The actual spending allocations from year to year will be determined through the annual planning and budgeting process.

Spending Allocation Targets

Changes in Spending Allocations



Conclusion

Implementation of the plan will create a shift in the primary focus in the delivery of health care from one of treating illness and injury in an institutional setting to the improvement of health and the treatment of illness and injury in the appropriate setting as close to home as possible.

There is evidence in Southwestern Ontario of the need for such a change, ranging from the limited resources spent on health promotion to the high use of institutional settings for the delivery of acute and long-term care.

The plan has been designed to achieve this change in direction through:

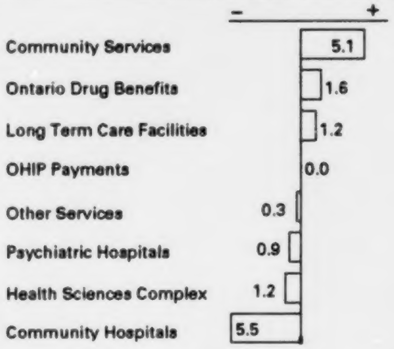
- a new system of governance closer to the people of Southwestern Ontario;
- the development of effective health promotion and disease prevention systems;

Spending Allocation Targets

- the establishment of a balanced system of community and institutional services supported by regional education and research;
- improvement in the planning and utilization of human resources, and
- capital investments which increase the efficiency and effectiveness of the health care system.

In order to achieve the directions set out in the plan, it will be necessary to reallocate financial resources within the health care system.

Reallocation of Health Care Spending
Between 1990/91 and 2000/01 (%)



The achievement of these reallocations will be difficult in a financial system which has been characterized by incrementalism. Fortunately, in the recent agreement between the Ontario Medical Association and the Provincial Government there is already evidence of change at the Provincial level.

Nevertheless, the financial change will inevitably be controversial. At the same time, the reallocation of financial resources within the total health care system will be fundamental to the achievement of the plan.

THE PLAN: TOWARDS BETTER MANAGEMENT OF OUR HEALTH

Summary

Successful implementation of the plan will require fundamental changes in how people view health and how people and organizations work together to plan, manage, and provide health services. Central to the achievement of change will be the difficult decision by the Government of Ontario to devolve its responsibility and accountability for managing the health system in Southwestern Ontario to the Regional and Area Boards.

An implementation body, located in the Region and managed by a full-time chairperson, will be established on an interim basis to ensure an effective and efficient transition to the new system of governance.

An appropriate legislative and policy framework will be established at the Provincial level for the creation of the new Boards and their associated managerial and financial responsibilities.

A careful, planned approach to the transfer of responsibilities to the new Boards by the Provincial Government will be required in order to avoid the duplication of resources and structures. Concurrent with the establishment of the new Boards will be a reduction in Provincial Government resources presently involved in the administration of the health care system in Southwestern Ontario. Highly qualified board members and executives, together with performance standards equivalent to those of large, private sector corporations with broad shareholder interest, will be essential for the effective management of the Regional and Area Health Boards.

In order to develop the support and commitment necessary for successful change, effective communication of the plan will be required, as well as the participation of all key players in the development of the new structure and planning processes for the health care system.

It will also be important to establish new management information systems which permit the on-going evaluation of the achievements of the plan, particularly with respect to improvements in health and in the efficiency of the health care system.

THE PLAN:
TOWARDS BETTER MANAGEMENT OF OUR HEALTH

Summary

Subject to obtaining the commitment to proceed and the establishment of the necessary legislative framework for the new structure, the new boards will commence operation at the beginning of the 1994/95 fiscal year.

Introduction

The plan for improving the health of the people of Southwestern Ontario represents a major undertaking which will result in a fundamental change in how the health system is governed, how programs and services are planned and provided and how health care resources are managed. Before implementation can proceed, it will be necessary for the Provincial Government to endorse fully and support devolution of much of its existing responsibility and resources for managing the health system. Most important will be the need for the Government of Ontario to pass on accountability for managing billions of dollars of public funds and for determining what health services will be provided in Southwestern Ontario within Provincial standards and guidelines.

Once the decision with respect to devolution has been made, a well-planned and managed implementation process will be critical to the achievement of the plan. In order to be successful, an implementation body will need to be created to ensure an orderly transition to the new system of governance. Consideration will also need to be given to establishing the legislative and policy framework for change, putting the new structure and resources into place through downsizing or replacing existing structures, communicating the plan, evaluating its outcomes and ensuring the timely implementation of change.

Implementation Body

An interim implementation body will be appointed by the Provincial Government with the mandate to oversee the effective and efficient transition to the new system of governance and to ensure that the necessary framework and resources are in place to permit the plan to be carried out over the next ten years. This body will exist only for as long as is necessary to establish the on-going Regional capability to manage the system. It will include representatives from the Provincial Government and from communities, service providers and Local Government throughout Southwestern Ontario.

The implementation body will be headed by a full-time chairperson who has strong credentials in management and will be located within the Region. The responsibilities of this body will include:

- seeking input from, and determining the roles of, the public, community representatives, service providers, the Provincial Government, Local Government, District Health Councils, and other organizations with respect to implementation;
- defining the new governance structure and the roles and responsibilities of its individual elements in specific terms, and
- establishing a critical mass of human and financial resources for the new structure.

The mandate of this body will not include negotiating the Region's funding envelope from the Provincial Government, planning for the health system or allocating funds within the Region. These tasks will be on-going responsibilities of the new Regional and Area Boards.

Legislative and Policy Framework

The plan provides an overall vision and strategic direction for the individuals and organizations who will be charged with the responsibility for its implementation. Before any meaningful change can take place, it will be necessary to establish appropriate Provincial legislation and policies to enable the new Regional and Area Health Management Boards to carry out their mandate; for example legislation needs to be put into place for the creation of the new Boards, the regionalization of OHIP payments, the integration of capital and operating costs, the transfer of local Government's portion of health unit funding to the new Boards and the establishment of human resource planning tools.

Organizational Change

Implementation of the new structure will require major changes to existing organizations involved in managing the health care system. The organizational structures, resources and operating budgets of the

Ministries of Health and Community and Social Services will need to be reduced along with the transfer of responsibilities to the new Regional and Area Health Management Boards. In addition, the five District Health Councils in Southwestern Ontario will no longer exist. The valuable experience and expertise of many individuals in these organizations needs to be preserved in the new system.

Successful implementation of the new system of governance will also depend on the calibre of board members and the quality of managers recruited for the new boards. Capable and committed volunteers and highly qualified executives with strong managerial skills and proven records of accomplishment will be essential. The performance of board members and senior management executives will need to be measured using standards equivalent to those of large, private sector corporate enterprises with broad shareholder interest.

Communication of the Plan

In order to develop the understanding and commitment necessary for successful change, it is vital that the new Boards have the support and participation of the public, service providers and Local Government in the development of the new structure and planning processes that will be used to establish and manage the new system. Effective communication, both within and beyond the Region, will be essential to the successful implementation of the plan. Furthermore, consideration will need to be given to education of the public throughout the implementation process.

Evaluation

The major goal of the plan is to ensure that the people of Southwestern Ontario will continue to be well served and that the Region's health care system and health status can be improved, despite the major constraints which are anticipated in public funding. It will be important to measure and evaluate the achievements of the plan toward this goal over the next ten years. Management information systems which are capable of evaluating individual programs as well as monitoring overall improvements in such factors as health status and system efficiency will need to be established for this purpose.

Timing

It is important that, once accepted and approved by the Provincial Government, the plan be implemented as expeditiously as possible. It must be recognized that there will be some uncertainty with respect to the timing of the political approval process. However, it should be possible to appoint the Regional and Area boards of directors, senior executives and staff, and to develop new management systems in time to commence operation at the beginning of the 1994/95 fiscal year. Once established, it will be important for the new boards to proceed immediately with implementation of the plan.

APPENDICES

WORKING TOGETHER TO ACHIEVE BETTER HEALTH FOR ALL

Commission Terms of Reference

Summary

A Planning Commission has been established to prepare a 10-year strategic plan for the health system in London and Southwestern Ontario. The plan will identify priorities so that health care resources can be allocated effectively. The majority of the membership of the Planning Commission will be drawn from London and Southwestern Ontario.

The London Health Science Centre is recognized as a centre of excellence in medical research and education for the province and maintaining this high standard of excellence will be a priority throughout this process.

Preamble

One of the underlying principles of the health system reform is the "vision that people have equitable access to effective, quality care, as close to home as possible and that they have the knowledge and, therefore the opportunity to be well. If we are to realize this vision, we must begin now to create the shifts that will move us in the directions that we want to move – in a planned, orderly and rational manner."

The Ontario Government has three major health reports which provide an agenda for reform. They are the Ontario Health Review Panel, chaired by Dr. John Evans; the Panel on Health Goals, chaired by Dr. Robert Spasoff; and the Minister's Advisory Group on Health Promotion, chaired by Steve Podborski.

In order to initiate the reform within Ontario, the Premier's Council on Health Strategy was formed. The Premier's Council has put forth this "Vision of Health".

"We see an Ontario in which people live longer in good health, and disease and disability are progressively reduced. We see people empowered to realize their full health potential through a safe, non-violent environment, adequate income, housing, food and education, and a valued role to play in family, work, and the community. We see people having equitable access to affordable and appropriate health care regardless of geography, income, age, gender or cultural background. Finally, we see everyone working together to achieve better health for all."

The Premier's Council on Health Strategy has also established goals which were adopted by the Government in its throne speech of April 25, 1989. These goals are:

Goal 1: Shift the emphasis to health promotion and disease prevention.

Goal 2: Foster strong and supportive families and communities.

Goal 3: Ensure a safe, high quality physical environment.

Goal 4: Increase the number of years of good health for the citizens of Ontario by reducing illness, disability and premature death.

Goal 5: Provide accessible, affordable, appropriate health services for all.

The Ministry of Health has developed a number of strategies to address these goals, for example:

- A framework for addressing hospital capital planning which includes establishing innovative and alternative directions in service delivery such as strong regional services which emphasize day treatment, outpatient and community support programs.
- The Long Term Care Reform which is designed to maintain the independence of Ontario's seniors and people with physical disabilities, support their caregivers and strengthen the ability of communities to plan and manage responsive services.

Generally speaking, Ontario already has the highest per capita spending of any jurisdiction with a National Health System. This is particularly alarming since Ontario has one of the youngest populations of any jurisdiction. In addition, London and the Southwest have one of the highest per capita spending within the Province, and a high rate of institutional use.

WORKING TOGETHER TO ACHIEVE BETTER HEALTH FOR ALL

Commission Terms of Reference

Scope of Review

Clearly, a strategic plan is required which has broad support and which identifies priorities for the total health system in London and the Southwest Region. In order that health care resources may be allocated in the most effective way, it has been decided that a strategic plan to the year 2001 should be developed for London and the Southwest Region.

This plan should recognize the importance of London as a local health care provider, as a regional resource, as a provincial resource, and as a major academic health science centre. This plan may serve as a model for regional planning for the Province of Ontario.

From a geographic perspective, the review will encompass the entire catchment population of the health services provided by London. London draws referrals from all of southwest Ontario (Essex, Kent, Lambton, Huron, Perth, Grey, Bruce, Elgin, Oxford, and Middlesex) and parts of central Ontario.

Goal of the London and Southwest Region Health System Review

To evolve a health system in the entire region that:

- provides London and environs with accessible, affordable, effective, and appropriate health services;
- ensures London continues as a centre of excellence in both research and education;
- ensures London institutions collaborate with and support the region in its provision of appropriate health services, including specialty care, as close to home as possible, and
- provides quality specialized patient care.

Major Themes for the Review

- To promote realignment and rationalization of services in the Southwest Region.

WORKING TOGETHER TO ACHIEVE BETTER HEALTH FOR ALL

Commission Terms of Reference

- To promote the shift in the provision of appropriate health care services from institutional-based to community-based.
- To promote the shift of appropriate specialty services to community facilities in the region.
- To support effective use of primary care services throughout the Southwest Region.
- To re-orient the system from the predominance of treatment of illness to a more balanced set of programs incorporating disease prevention and health promotion.
- To re-examine capital requirements in London and the Southwest Region and study the need to redirect resources to more appropriate services and settings.
- To create closer links between institutional care and community services.
- To incorporate the reform plan for long term care in Ontario.
- To incorporate the Capital Planning Framework which facilitates rational priority setting.
- To seek innovative ways of providing cost-effective health services and programs.
- To develop a system which will enhance the health status of the population in the area.
- To examine the current planning structures and processes for the health system in London and Southwest Ontario.
- To ensure that District Health Councils and all appropriate health care partners affected by health systems reviews (e.g. hospitals, community agencies) are consulted and kept informed of the ongoing progress of the review.

Outcomes of the Review

- Strategic directions to maintain the level of excellence of the London Health Science Centre
- The identification of opportunities to strengthen linkages between services offered within London and those provided in other parts of Thames Valley and the Southwest Region
- The identification of opportunities to increase specialty care services outside of London
- The identification of opportunities for increased community-based and outpatient services consistent with the long term care reform, recommendations of the Premier's Council on Health Strategy and other Ministry initiatives
- The rationalization of the roles of service providers within the region, e.g., primary, secondary, tertiary
- The identification of opportunities for more effective use of existing resources, e.g. reallocation of resources and redirection of programs
- Strategies to enhance the health status of the population
- A strategic capital plan with broad support which aligns with priorities for the health system in London and the Southwest Region
- The identification and consideration of moving designated provincial services provided by London to other areas such as central and northern Ontario
- To facilitate implementation of the plan through framing recommendations on:

  1) the strengthening of the regional planning structure in association with Southwestern Association of Chairmen of District Health Councils, and

2) supporting community and provincial planning through Thames Valley District Health Council within available resources.

The review will focus on the total health system, with a view to establishing local linkages in the Ministry's main lines of Institutional Health, Community and Personal Health. The report will reflect the policy and administrative framework within which the health system is being managed.

Capital Issues

Any capital plans for London which impact on service delivery must be reviewed in the broader context and will be considered by the Planning Commission. The Commission will forward its comments to Thames Valley District Health Council.

Any capital plans in the southwest region which have an impact on the delivery of services by the Health Science Centre will also be reviewed by the Planning Commission with comments forwarded to the appropriate District Health Council. Capital plans that have no impact or do not change current health services will not be forwarded by District Health Councils to the Planning Commission but will continue to be reviewed by individual DHCs. The Planning Commission should be kept informed of all major capital investment in the region.

Planning Commission Process

Sub-committees

Sub-committees will be established to provide studies on specific aspects of the health system. The sub-committees should represent a cross-section of interests, including London and the region, consumer and provider groups, Ministry of Community and Social Service representatives, social service agencies, public health units, academics, etc.

Each sub-committee will report to the Planning Commission.

Communications

The Planning Commission will develop a communications plan to facilitate public consultation and to provide an open process for broad community discussion.

Project Staffing

A project manager accountable to the Planning Commission will be hired to provide ongoing support. This person will be employed by Thames Valley District Health Council and funded by the Ministry. The project manager will be supported by the other DHCs in the region through such mechanisms as secondments and loan of staff.

Ministry Support

The Ministry will have a strong liaison with the steering committee. Ministry staff will be available as resources to the steering committee and sub-committees as required.

The Ministry will provide 100% of the funding for staff and administrative costs associated with the review.

Timeframe

The review will be undertaken in phases with recommendations and strategic directions forwarded to the Minister at the end of each phase. Interim reports will be submitted on a biannual basis.

Within ninety days of initiation of the health system review, the Planning Commission will have recommendations for the Minister on the request for replacement of the 187 beds at St. Mary's Hospital in London.

It is expected that the review will be completed in approximately eighteen months.

The specific methodologies, process, and workplan will be developed by the Planning Commission.

February 1, 1990.

WORKING TOGETHER TO ACHIEVE BETTER HEALTH FOR ALL

Commission Membership

Earl Orser (Chair)
Chairman of London Life Insurance Company and London Insurance Group

Blair Barons, R.N. (Co-Chair)
Immediate Past-Chair of the Thames Valley District Health Council
Resigned December 10, 1990

Kathy Desai
Director of the Oxford County Board of Health Home Care Program

Cathy Dunlop, R.N., MSc.N.
Professor of Nursing at Fanshawe College in London, Ontario

Roxy Edwards
Executive Director of the Bruce Peninsula Health Services

Dr. Ramsay Gunton
Cardiologist at University Hospital in London, Ontario

Dr. Andrew Hackett
Family Physician in Guelph, Ontario

J. Douglas Lawson, Q.C.
Partner in the Windsor law firm of McTague, Clark

Dr. Verna Mai
Medical Officer of Health of the Elgin St. Thomas Health Unit

Janet McEwen
Councillor and Controller of the City of London

Dean Duncan Sinclair
Vice-Principal, Health Sciences and Dean of Medicine, Queen's University, Kingston, Ontario

Conflicts Of Interest

The following Commissioners have considered themselves to have had a conflict of interest in the matters listed:

1. Ramsay W. Gunton, M.D., F.R.C.P.(C): The London Health Sciences Complex.

Health Status Task Force

Terms of Reference

Determine the future population's health status and health and social services needs.

Chair

Ramsay Gunton/Verna Mai

Membership

Robert Alder
Carol Buck
Thomas Burch
Nora Ho
Daryl Weinkauf

Reports

Disease-Specific Mortality Trends in Southwestern Ontario

Variation in Healthcare Service Use in Ontario: An Analysis of Associated Factors

Impact of Demographic Changes on Health Service Use: Southwestern Ontario 1986 to 2001

Consultants

Middlesex-London Health Unit
Population Studies Centre, University of Western Ontario

Health Promotion and Disease Prevention Task Force

Terms of Reference

Develop a public health education plan for the next ten-year period.

Chair

Catherine Dunlop/Kathy Desai

Membership

Martin Bass
Eleanor Graham
Barrie Evans
Allen Heimann
Elsabeth Jenson
Alison Mahon
Brenda Mitchell
Naomi Rae-Grant
Jennifer Roy
Mary Shamley

Report

Promoting Health in Southwestern Ontario

Consultants

Chelsea Group Communications

Governance and Management Task Force

Terms of Reference

Determine the appropriate governance, administration and management structure of the health and social services system for Southwestern Ontario for the year 2001 and beyond.

Chair

Earl Orser/Duncan Sinclair

Advisors

Gordon Osbaldeston
Graham Scott

Report

Governance and Management Report

Consultants

Deloitte Touche
Nick Bosanquet

Core Model Task Force

Terms of Reference

Develop a "core" model of appropriate services and appropriate levels of services for a healthy community.

Chair

Janet McEwen/Verna Mai

Report

Core Model Report

Consultants

Deloitte Touche

Human Resources Task Force

Terms of Reference

Determine prospective surpluses/shortages in categories of professional and other human resources over the next ten year period and prepare plans for rebalancing.

Chair

Roxy Edwards

WORKING TOGETHER TO ACHIEVE BETTER HEALTH FOR ALL

Commission Task Forces and Other Studies

Reports

Human Resources Planning in the Health System in the Southwestern Region of Ontario

Limiting Physician Costs - A Brief Summary

Consultants

Johnston Smith Fromkin McCulloch

Other Studies/Reports

Future Capital Spending in the Southwest Region
(Agnew Peckham)

Consumer Health Attitude Study for Southwestern Ontario
(Marketbeat)

Situation Analysis - Southwest Region
(Commission)

Other Consultants

Price Waterhouse
(Development of Commission Questionnaire)

Media Concepts Communications

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First Commission Public Consultation Process: Locations, Dates, and Participants

Location	*Date*
Bruce County Walkerton, Ontario	November 12, 1990
Elgin County St. Thomas, Ontario	November 13, 1990
Essex County Windsor, Ontario	October 29, 1990 November 2, 1990 November 5, 1990
Grey County Owen Sound, Ontario	October 29, 1990
Huron County Goderich, Ontario	November 8, 1990
Kent County Chatham, Ontario	October 25, 1990
Lambton County Sarnia, Ontario	November 16, 1990 November 19, 1990
Middlesex County London, Ontario	November 1, 1990 November 2, 1990 November 8, 1990
Oxford County Woodstock, Ontario	November 12, 1990
Perth County Stratford, Ontario	November 16, 1990

Participants

Addiction Research Foundation
Alexandra Marine & General Hospital
Canadian Hearing Society
Canadian Mental Health Association

WORKING TOGETHER TO ACHIEVE BETTER HEALTH FOR ALL

First Commission Public Consultation Process: Locations, Dates, and Participants

Clinton Public Hospital
Charis House Hospice
Charlotte Eleanor Englehart Hospital
Cheshire Homes
Corporation of the City of London
County of Lambton Home for the Aged
Extendicare Health Services Incorporated
Four Counties General Hospital
Gottschall, Elaine
Hayne, John
Hinde, A. J.
Huron County Health & Social Services Liaison Committee
Huron County Health Unit
Hospice of London
Kent-Chatham Health Unit
Lambton Elderly Outreach
Lambton Chiropractic Society
Lambton County Health Unit
Listowel Memorial Hospital
London Chiropractic Society
London Cultural Interpretation Services
London Family Court Clinic
London-Middlesex Victorian Order of Nurses
London Psychogeriatric Clinic
London Psychological Association
London Regional Cancer Centre
London Teaching Hospitals' Council
Matthew's Gerontological Services
Meals On Wheels London
Medic Aid Response Systems
Middlesex Seniors Support Advisory Committee
Naturopathic Medicine
Owen, Helen
Ontario Chiropractors' Association
Ontario Council of St. John's Ambulance
Oxford County Board of Health
Oxford County Home Care Program

Oxford County Medical Society
Oxford County Right to Life
Oxford County Victorian Order of Nurses
Public General Hospital (Chatham)
Parkwood Hospital
Perth County Health Unit
Roaul Wallenburg Centre
St. Joseph's Health Centre (London)
St. Joseph's Hospital (Chatham)
St. Joseph's Hospital (Sarnia)
Sarnia & District Children's Treatment Centre
Sarnia General Hospital
Sarnia Home Care Program
Seniors Advisory Council
South Huron Hospital
Spruce Lodge
Stratford General Hospital
Stratford Neighbourly Services Association
Strathroy Middlesex General Hospital
Strathroy Public Hospital
Sydenham District Hospital
Thames Valley Placement Coordination Services
Thames Valley Regional Geriatric Program
University Hospital
University of Western Ontario - Department of Physical Medicine & Rehabilitation
Victoria Hospital Corporation
Wharncliffe Family Physicians
Woodstock General Hospital
YMCA Stratford/Perth

WORKING TOGETHER TO ACHIEVE BETTER HEALTH FOR ALL

Second Commission Public Consultation Process (Round Table Meetings): Locations, Dates, and Participants

Location	*Date*
Bruce County Walkerton, Ontario	October 8, 1991
Elgin County St. Thomas, Ontario	September 26, 1991
Essex County Windsor, Ontario	October 3, 1991 October 28, 1991
Grey County Owen Sound, Ontario	October 1, 1991
Huron County Goderich, Ontario	October 24, 1991
Kent County Chatham, Ontario	October 23, 1991
Lambton County Sarnia, Ontario	October 11, 1991
Middlesex County London, Ontario	October 17, 1991 October 29, 1991
Oxford County Woodstock, Ontario	October 2, 1991
Perth County Stratford, Ontario	September 19, 1991

Participants

Addiction Research Foundation (London)
Addiction Research Foundation (Chatham/Sarnia)
Addiction Research Foundation (Windsor)
AIDS Committee of London
Alexandra Hospital
Alexandra Marine & General Hospital
Alpha Apartment Living

WORKING TOGETHER TO ACHIEVE BETTER HEALTH FOR ALL

Second Commission Public Consultation Process (Round Table Meetings): Locations, Dates, and Participants

Alzheimer Society (Chatham/Kent)
Alzheimer Society (Owen Sound)
Alzheimer Society (St. Thomas)
Alzheimer Society (Windsor)
Association for Community Living (Essex County)
Association of Treatment Centres of Ontario
Barkin, Martin
Big Brothers of Sarnia Lambton
Bremner, Helen
Bruce-Grey-Owen Sound Health Unit
Brunner Nursing Home
Canadian Cancer Society (Southwestern District)
Canadian Diabetes Association (Windsor Branch)
Canadian Mental Health Association Grey/Bruce
Canadian Mental Health Association (London-Middlesex)
Canadian Mental Health Association of Windsor & Essex County
Canadian National Institute for the Blind (Owen Sound)
Canadian National Institute for the Blind (Sarnia)
Canadian Red Cross Society
Catholic Health Association
Catholic Women's League
Centre Grey General Hospital
Charlotte Eleanor Englehart Hospital
Chateau Park Nursing Home
Cheshire Homes of London
City of Stratford
City of Windsor
Chatham-Kent Community & Family Services
Children's Achievement Centre
Children's Psychiatric Research Institute
Clinton Public Hospital
Community Services for the Developmentally Handicapped
Council of Chronic Hospitals of Ontario
Country Village
County of Bruce General Hospital
County of Huron Health Unit
Dawson, Angela

Demarco, Frank
Directors of Physiotherapy
District Health Councils of Southwestern Ontario
Donaldson, Heather
Easter Seal Society
Economic Council of Canada
Edwards, G. L.
Elgin County Homes
Elgin County Seniors Advisory Committee
Elgin-St. Thomas Health Unit
Elgin-St. Thomas Home Care Program
Ellis, Peter
Elmwood Place Retirement Community
Essex County District Health Council
Essex County Medical Society
Fair Haven
Farrell, N. A.
Feagan, Sherly
Four Counties General Hospital
French Language Services
Gateway Haven
Gerintological Nurses Association
Goderich Medical Centre
Golden Years Advisory Committee for Schizophrenia
Grey Bruce Community Health Corporation
Grey-Bruce District Health Council
Grey Bruce Home Care Program
Grey-Bruce Regional Health Centre
Haldimand-Norfolk District Health Council
Hanover & District Hospital
HARC Incorporated
Health Awareness Stratford
Hospice of London
Hotel Dieu of St. Joseph
Huron County Home Care Program
Huron County Medical Society
Huron Health & Social Services Liaison

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Second Commission Public Consultation Process (Round Table Meetings): Locations, Dates, and Participants

Huron Lodge Home for the Aged
Huron-Perth Centres for Children & Youth
Information & Services Development for Seniors and the Physically Disabled
Interim Regulatory Council on Midwifery
Jensen, Elsabeth
Kennedy, Leslie
Kent County District Health Council
Kent County Home Care Program
Kincardine & District General Hospital
Kinhuron Medical Centre
La Leche League
Lambton County District Health Council
Lambton County Lung Association
Lambton County Medical Society
Lambton Psychogeriatric Consultation Service
Lambton Seniors Association
Lambton Twilight Haven
Le Tarte, Pierre
Linton, Adam
Listowel Memorial Hospital
London & District Academy of Medicine
London Birth Centre
London Cultural Interpretation Services
London Psychiatric Hospital
London Regional Cancer Centre
London Regional Psychological Association
London Teaching Hospitals' Council
Matheson Chiropractic Clinic
McAllister, Janet
McDonald, Paul
McKellar, Laurie
Meaford General Hospital
Med-care
Metropolitan General Hospital
Metropolitan Toronto District Health Council
Middlesex-London Health Unit

WORKING TOGETHER TO ACHIEVE BETTER HEALTH FOR ALL

Second Commission Public Consultation Process (Round Table Meetings): Locations, Dates, and Participants

Midwifery Task Force
Morgan, Mary Ann
Mustard, Fraser
Naturopathic Medicine
Neal, Don
Nurse Practitioner's Association
Ontario Council of Teaching Hospitals
Ontario Hospital Association
Ontario Nurses Association
Ontario Medical Association (Essex/Kent/Lambton)
Ontario Society of Occupational Therapists
Ostbye, Truls
Oxford County Health Unit
Oxford County Medical Society
Oxford Regional Nursing Home
Parkwood Hospital
Perth District Health Unit
Palmerston & District Hospital
Para-med Health Services (St. Thomas)
Para-med Health Services (Sarnia)
Perinatal Outreach Program
Public General Hospital
Raoul Wallenburg Centres Inc.
Registered Nurses' Association of Ontario
Reliacare Inc.
Right to Life Kent
Right to Life Lambton
Rochard, Cecile
Rockwood Terrace Home for the Aged
Rodney Ambulance Service Ltd.
Rourke, James
St. Clair College
St. Mary's Memorial Hospital
St. Joseph's Health Centre (London)
St. Joseph's Health Centre (Sarnia)
St. Joseph's Hospital (Chatham)
St. Thomas-Elgin General Hospital

WORKING TOGETHER TO ACHIEVE BETTER HEALTH FOR ALL

Second Commission Public Consultation Process (Round Table Meetings): Locations, Dates, and Participants

St. Thomas Psychiatric Hospital
St. Thomas Physiotherapy Clinic
Salvation Army Grace Hospital
Sandwich Community Health Centre
Sarnia & District Children's Treatment Centre
Sarnia Friends of Schizophrenics
Sarnia General Hospital
Sarnia-Lambton Health Unit
Sarnia-Lambton Home Care Program
Seaforth Community Hospital
Sexual Assault Centre
Sisters of St. Joseph of Hamilton
Steckle. Paul
Steinmann, Darla
Stratford Ambulance Service
Stratford General Hospital
Summerfield, Michael
Sydenham District Hospital Corporation
Teen Health Centre
Thames Valley Children's Treatment Centre
Thames Valley District Health Council
Thames Valley Placement Coordination Services
Thamesview Lodge
Tillsonburg & District Association for Community Living
United Ostomy Association
United Way of London
University Hospital
University of Western Ontario - Faculty of Applied Sciences
University of Western Ontario - Faculty of Medicine
University of Western Ontario - Faculty of Nursing
University of Western Ontario - Faculty of Part-time Studies
University of Western Ontario - Psychogeriatric Group
University of Windsor - Faculty of Nursing
Upjohn Health Services
Van der Hoeven, Leonard
Versa-care Centre
Victoria Hospital Corporation

Victoria Hospital Family Medicine
Victorian Order of Nurses (London)
Victorian Order of Nurses (Owen Sound)
Victorian Order of Nurses Oxford County
Victorian Order of Nurses (Point Edward)
Victorian Order of Nurses (Windsor)
Western Ontario Therapeutic Community Hostel
Windsor Essex County Health Unit
Windsor Regional Cancer Centre
Windsor Western Hospital Centre Inc.
Wingham & District Hospital
Woodstock General Hospital

WORKING TOGETHER TO ACHIEVE BETTER HEALTH FOR ALL

Commission Meeting Dates

March 30, 1990

April 6 - 8, 1990

May 4, 1990

June 21, 1990

July 11, 1990

July 27, 1990

August 17, 1990

September 21 - 23, 1990

October 12, 1990

December 9, 1990

January 19, 1991

February 15, 1991

March 1 - 2, 1991

March 23, 1991

April 13, 1991

April 26 - 27, 1991

May 10, 1991

May 23 - 25, 1991

June 7, 1991

June 27 - 28, 1991

July 6, 1991

July 19, 1991

July 27, 1991

August 15 - 16, 1991

September 14, 1991

October 18, 1991

November 1 - 2, 1991

November 30, 1991

WORKING TOGETHER TO ACHIEVE BETTER HEALTH FOR ALL

Presentations Received at Commission Meetings

Presentation By	*Date*
The Honourable Elinor Caplan Minister of Health	March 30, 1990
Dr. L. S. Valberg Dean of Medicine, University of Western Ontario	April 6-8, 1990
Mr. J. O'Neill, Chairman Mr. P. Hassen, President St. Joseph's Health Centre	June 21, 1990
Dr. M. J. Fulton Assistant Professor, Faculty of Administration University of Ottawa	June 21, 1990
Dr. M. Barkin Deputy Minister of Health of Ontario	July 11, 1990
Ms. M. Shamley Ms. E. Ross Ms. S. Radcliffe Ms. P. Folsom Dr. N. Rae-Grant Ms. T. Bisset Premier's Council on Health Strategy	July 27, 1990
Mr. J. Kaufman Assistant Deputy Minister of Health of Ontario	July 27, 1990
Professor E. Shapiro Faculty of Medicine, University of Manitoba	August 17, 1990
Dr. T. Hancock Professor, York University	January 19, 1991
Dr. M. Barkin Deputy Minister of Health of Ontario	February 6, 1991
The Honourable Evelyn Gigantes Minister of Health	March 1, 1991

WORKING TOGETHER TO ACHIEVE BETTER HEALTH FOR ALL

Presentations Received at Commission Meetings

Dr. R. MacMillan Executive Director, Health Insurance Division Ministry of Health of Ontario	March 2, 1991
Ms. M. Shamley Premier's Council on Health Strategy	April 13, 1991
Ms. G. Ure Community Support Services Ministry of Community and Social Services	April 26, 1991